PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

☐ **Growth** - I am concerned about my child's growth.

☐ **Appetite** - I am concerned about my child's eating/feeding habits or appetite.

☐ **Rest** - I am concerned about the amount of sleep my child needs.

☐ **Illness/Surgery/Injury** - My child had a serious illness, injury, or surgery.

Please describe:

☐ **Physical Activity** - My child must restrict physical activity.

Please describe:

☐ **Development and Learning** - I am concerned about my child's behavior, development, or learning.

Please describe:

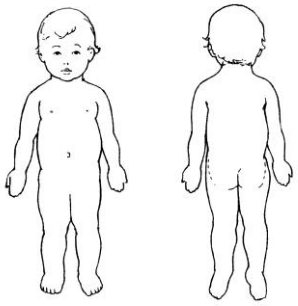
☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has skin problems, birthmarks, Mongolian spots, etc.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Nervous System, headaches, seizures
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Needs special equipment.

List equipment:

☐ **Medication**[1] - My child takes medication.

Medication Name	Time Given	Reason for Medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at www.idph.iowa.gov/hcci/products

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature (required) _____ Date: _____

[1] Please review the child care program's policies about the use of medication at child care.