DOCTORS COMPLETE THIS PAGE[1]

Child's Name:

Birthdate: **Age today:**

Date of Exam:

Height or Length:

Weight

Head Circumference (for children under 2 yr.):

Body Mass Index (for children over 2 yr.):

Blood Pressure (start @ age 3 yr.):

Hgb. or Hct.: (start @ 1 yr.)

Blood Lead Level: (start @ 1 yr.)

Sensory Screening:

Vision Right eye _____ Left eye _____

Hearing Right ear _____ Left ear _____

Tympanometry (attach results)

Developmental Screening:

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

Developmental Referral Made Today: ☐Yes ☐No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Date of Last **Dental** Exam: _____

Dental Referral Made Today: ☐Yes ☐No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed physician comments or instructions

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

Immunization: Doctor may attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td

Hepatitis B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

TB testing (for high risk child only)

Medication: Physician authorizes the child may receive the following medications while at child care: (include *over-the-counter* and *prescribed*)

Medication Name Dosage

☐ Diaper crème:

☐ Pain reliever:

☐ Sunscreen:

☐ Cough medication

Other Medication should be listed with written instructions for use in child care.

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563

Health Provider Assessment Statement:

☐The child may participate in developmentally appropriate child care/preschool with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate child care/preschool ***with these restrictions***:

Doctor Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone