

## Infant, Toddler, Preschool Age – Child Health Exam Form

### PARENTS COMPLETE PAGES 1 and 2 – child information

Child's name		Child's birthdate	Name of center, provider, or preschool
Parent 1 name		Telephone #	
Parent 2 name			
Child home address #1		Telephone # 1	
Child home address #2		Telephone #2	
Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email	
Where parent # 2 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email	
<p>In the event of an emergency, the child care provider is authorized to obtain <b>EMERGENCY MEDICAL</b> or <b>DENTAL CARE</b> even if the child care center is unable to immediately make contact with the parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.</p>			
Parent/Guardian Signature: _____		Date _____	
Alternate emergency contact person's name: _____		Relationship to child: _____	
		Phone number: _____	
Child's doctor's name	Doctor telephone # 1	Hospital choice	
Doctor's address	After hours telephone #	Does your child have health insurance? <input type="checkbox"/> Yes, Company _____ ID #	
Child's dentist's name	Dentist Telephone # 1	Does your child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID#	
Dentist's Address	After hours telephone #	<input type="checkbox"/> NO, we do not have health insurance. <input type="checkbox"/> NO, we do not have dental insurance.	
Other health care specialist name	Telephone #	<input type="checkbox"/> Please help us find health or dental insurance.	
Type of specialty			

Child Name: \_\_\_\_\_

**PARENTS COMPLETE THIS PAGE**

**Parents:** 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 doctor 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**

has had a serious illness, surgery, or injury. *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:*

**Medication** - My child takes medication.

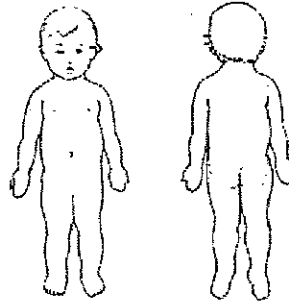
List meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

**Child's Name:** \_\_\_\_\_

**Body Health - My child has problems with**

Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe any skin markings



- Eyes \ vision, glasses
- Ears \ hearing, hearing aides or device, ear-aches, tubes in ears
- Nose problems, nosebleeds, runny nose
- Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough, croup
- Heart, heart murmur
- Stomach aches, upset stomach, colic, spitting up
- Using toilet, toilet training, urinating
- Bones, muscles, movement, pain with moving
- Mobility, uses assistive equipment
- Nervous system, headaches, seizures, or nervous habits (like twitches)
- Needs special equipment. *Please describe:*

**Allergies** - My child has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). *Please describe.*

Parent questions or comments for the health care provider:

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

DOCTORS COMPLETE THIS PAGE<sup>1</sup>

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

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

<sup>1</sup> 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

Child's Name \_\_\_\_\_ Class \_\_\_\_\_

### Indianola Preschool Inc. Emergency and Illness Information

\*Please list phone numbers where parent(s) or guardian(s) may be reached during preschool hours.

Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone(\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone(\_\_\_\_) \_\_\_\_\_

\*Please list AT LEAST TWO names and phone numbers, other than your own, who may be contacted in case of an emergency or illness. It is IMPORTANT that the listed numbers are people that could come pick up your child from preschool immediately in the event of an illness or emergency. **NOTE: As this information is used for IMMEDIATE contact, please list Indianola phone numbers only!**

Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone(\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Cell Phone(\_\_\_\_) \_\_\_\_\_

\*It is required by law that we have the following information in our files for emergency contacts:

Physician's Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Insurance Company \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

### **Emergency Medical Consent Form**

I, \_\_\_\_\_, (mother/father/legal guardian) of \_\_\_\_\_, (child's full name) do hereby give my permission and/or consent to the personnel of Indianola Preschool, Inc., Indianola, Iowa, to secure and authorize such emergency medical or dental care and/or treatment as my child (above named) might require while under the supervision of said preschool personnel. I also agree to pay all costs and fees contingent on any emergency medical or dental care and/or treatment for my child as secured or authorized under this consent.

Date \_\_\_\_\_

Signed \_\_\_\_\_

Mother/Father/Legal Guardian

Class \_\_\_\_\_

## Indianola Preschool Inc. Enrollment Form

### \*Identification Information

Child's Name \_\_\_\_\_ Name child goes by \_\_\_\_\_ Boy \_\_\_\_\_ Girl \_\_\_\_\_

Address \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Email address \_\_\_\_\_

Father's Place of Employment \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_\_

Mother's Place of Employment \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_ Cell(\_\_\_\_)\_\_\_\_\_

Daycare Provider 's Name \_\_\_\_\_ Phone(\_\_\_\_)\_\_\_\_\_  
Cell (\_\_\_\_)\_\_\_\_\_

### \*Pick-Up Permission

I hereby give permission for my child to leave the preschool with the persons named below. It is the responsibility of the parent(s) or guardian to notify the preschool, in writing, of any changes.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

Mother/Father/Legal Guardian

**Please Note:** If there is someone who may **NOT** pick up your child, the preschool **MUST** have a copy of the Court Order to that effect. Please submit it with this form.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

Mother/Father/Legal Guardian

Child's Name \_\_\_\_\_ Class \_\_\_\_\_

**INDIANOLA PRESCHOOL, INC.**

**Permission Form**

**Field Trip Permission**

I understand that field trips are an integral part of the curriculum, and that I will be asked permission for each field trip as it approaches. I hereby give my permission for the staff and volunteers of Indianola Preschool, Inc. to take my child, \_\_\_\_\_, on field trips while he/she is in the program.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Mother/Father/Legal Guardian

**Picture Release Agreement**

I hereby give my permission/ consent to let my child, \_\_\_\_\_, be photographed for preschool use. I understand that photograph may be used in the newspaper or other media as deemed appropriate by Indianola Preschool, Inc.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Mother/Father/Legal Guardian

**Sunscreen Permission**

I hereby give my permission and/or consent to the personnel of Indianola Preschool, Inc., Indianola, Iowa, to apply sunscreen to \_\_\_\_\_, (child's full name), when needed for outdoor play.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Mother/Father/Legal Guardian

**Toothbrushing Permission**

I hereby give my permission and/or consent to the personnel of Indianola Preschool, Inc., Indianola, Iowa, to supervise \_\_\_\_\_, (child's full name), while he/she is brushing their teeth during school time.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Mother/Father/Legal Guardian