**HEALTH PROFESSIONAL COMPLETE PAGE**  
**OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)**

<table>
<thead>
<tr>
<th>Date of Exam: ___________________</th>
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**Height/Length:** ___________  
**Weight:** ___________

**BMI** – starting at age 24 mo.: ___________

**Head Circumference** @ age 2 yr. and under: ___________

**Blood Pressure**-start @ age 3 yr.: ___________

**Hgb or Hct** @ 12 mo.: ___________

**Lead Risk Assessment:** ___________

**Blood Lead Level** @ 1 yr. & 2 yr.: date____ results_______

**Sensory Screening:**

<table>
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<tr>
<th>Vision Assessment: ___________________</th>
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**Vision Acuity:** Right eye _______ Left eye _______

**Hearing Assessment:** Right ear _______ Left ear _______

**Tympanometry** (may attach results)

**Developmental Screening/Surveillance:**

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<th>(n = normal limits) otherwise describe</th>
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Developmental screening results:

**Autism screening results:**

**Psychosocial/behavioral results**

**Developmental Referral Made Today:** Yes  No

**Exam Results:**

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**HEENT**

**Oral/Teeth Date of Dental exam** ___________

**Oral Health/Dental Referral Made Today:** Yes  No

**Heart**

**Lungs**

**Stomach/Abdomen**

**Genitalia**

**Extremities, Joints, Muscles, Spine**

**Skin, Lymph Nodes**

**Neurological**

**Allergies**

<table>
<thead>
<tr>
<th>Environmental:</th>
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<table>
<thead>
<tr>
<th>Medication:</th>
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</table>

<table>
<thead>
<tr>
<th>Food:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Insects:</th>
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<table>
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<tr>
<th>Other:</th>
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</table>

**Immunization and TB Testing:** (check as indicated)

- [ ] IDPH Certificate of Immunization reviewed and signed
- [ ] TB testing completed (only for high-risk child)

Health provider authorizes the child may receive the following at child care: (include **over-the-counter medications**)

- [ ] Diaper cream/ointment:
- [ ] Fever or Pain reliever:
- [ ] Sunscreen:
- [ ] Other

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at [https://hhs.iowa.gov/hcci/products](https://hhs.iowa.gov/hcci/products)

**Additional Referrals made:**

<table>
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<th>____________________________________</th>
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**Health Provider Assessment Statement:**

- [ ] The child may participate in developmentally appropriate early care/learning with **NO** health-related restrictions.
- [ ] The child may participate in developmentally appropriate early care/learning **with restrictions** (see comments).
- [ ] The child has a special needs care plan

**Type of plan** ___________

(See comments and complete and give to parent for child care templates at [https://hhs.iowa.gov/hcci/products](https://hhs.iowa.gov/hcci/products))

**Comments:**

<table>
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<tr>
<th>____________________________________</th>
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</table>

**Signature**

<table>
<thead>
<tr>
<th>Circle Provider Type: MD  DO  PA  ARNP  Chiropractor</th>
</tr>
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</table>

<table>
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<tr>
<th>Address: Telephone:</th>
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</table>

**Comments:**

**Medical record number:**

**Parent or guardian’s signature:** __________________________________

**Date:** __________________

<table>
<thead>
<tr>
<th>Healthcare provider’s name and signature:</th>
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</thead>
</table>

**Comments:**

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) [https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767298.1525549573.1674649657-346854326.1661880568](https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767298.1525549573.1674649657-346854326.1661880568)

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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.

☐ Physical Activity - My child must restrict physical activity.

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

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

☐ 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.

☐ 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.

☐ Medication¹ - My child takes medication.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Time Given</th>
<th>Reason for Medication</th>
</tr>
</thead>
</table>

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

1 Please review the child care program’s policies about the use of medication at child care.