



SCOTT COUNTY HEALTH DEPARTMENT
 Administrative Center
 600 W. 4th Street
 Davenport, Iowa 52801-1030
 Office: (563) 326-8618 Fax: (563)326-8774
www.scottcountyiowa.com/health



Public Health
 Prevent. Promote. Protect.

Dear Parent/Guardian,

Preschool is one of the first steps in your child’s school career. You should make sure your child is healthy, up to date on his/her immunizations, and has a physical before starting preschool. **Iowa Law requires** your child to have the following immunizations before coming to preschool:

Preschool Requirements

4 DTaP
3 Polio
1 MMR on or after 12 months of age
1 Varicella on or after 12 months of age (or parent’s report of Chickenpox)
3 Hib – with the final shot on or after 12 months of age* or 1 Hib shot on or after 15 months of age
4 Pneumococcal (Pneumovax, PCV) if received 3 shots under 12 months of age; or 3 shots if received 2 shots under 12 months of age, or 2 shots if received 1 shot under 12 months of age or received 1 shot between 12 and 23 months of age; or 1 shot if no shots had been received before 24 months of age.

An Iowa Certificate of Immunization *must be filled out* and can only be signed by a medical professional (Medical Doctor (MD), Doctor of Osteopath (DO), Physician’s Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Licensed Practical Nurse (LPN) or Certified Medical Assistant (CMA).

Your child is required to have a physical before entering preschool. This physical must be done by a MD, DO, PA or NP. The physical must be done within the past 12 months, and updated with a new physical when a year has passed. A dental exam and eye exam is important to have done, but not needed for preschool.

Please call me at (563)326-8618, ext. 8821, if you have questions about health information needed for preschool in Iowa. Please call the preschool your child is going to for questions about due dates for forms.

Sincerely,

Megan Kempen, RN, BSN
 Child Care Nurse Consultant

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name		Child's birthdate	Name of center, provider, or preschool
			Telephone #
Parent 1 name		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 EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parent/guardian. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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 child have health insurance? <input type="checkbox"/> Yes, Company _____ ID #	
Child's dentist's name	Dentist Telephone # 1	Does 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

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:*

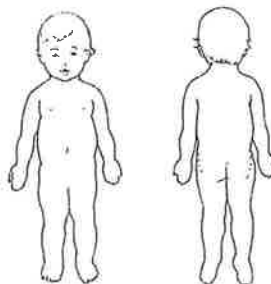
Medication - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

Child's Name: _____

Body Health - My child has problems with

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

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



- 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

HEALTH PROFESSIONAL COMPLETE THIS PAGE¹

Child's Name: _____

Birthdate: _____ Age today: _____

Date of Exam: _____

Height/Length: _____

Weight: _____

Head Circumference—for children age 2 yr and under: _____

Blood Pressure—start @ age 3 yr: _____

Hgb or Hct—anytime between 6-9 mo: _____

Blood Lead Level—start @ 12 mo: _____

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening²:

Developmental screening results: _____

Autism screening results: _____

Psychosocial/behavioral results: _____

Developmental Referral Made Today: Yes No

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

HEENT

Oral/Teeth

Oral Health/Dental Referral Made Today: Yes No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

For information on this page for detailed information on requirements pertaining to enrollment of child in child care contact:

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

² Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Immunization: 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 (only for high-risk child)

Medication: health professional authorizes the child may receive the following medications while at child care or preschool: (include over-the-counter and prescribed)

Medication Name

Dosage

Cough medication

Diaper crème:

Fever or Pain reliever:

Sunscreen:

Other

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 the following restrictions:**

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP

Health Care Provider comments or instructions:

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care³

Health Provider's Guide	AGE ⁴											
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History: Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Measurement: Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●			
Blood Pressure											●	●
Nutrition Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment⁵	●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Developmental Screening					●			●		●		
Autism Screening								●	●			
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen: Vision	S	S	S	S	S	S	S	S	S	O	O	O
Hearing ⁶	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations: per Iowa schedule ⁷	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hemoglobinopathy/Metabolic Screen	● ⁸											
Hematocrit or Hemoglobin					●→		◆					→
Urinalysis												●
Lead Test						●		◆		◆	◆	◆
Cholesterol Screen									◆			→
TB test ¹⁰						◆						→
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Tricycle Helmet Counseling									●	●	●	●
Sleep Position Counseling	●	●	●	●	●	●						
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed
 ◆ = to be performed for high-risk children
 → = Range in which the task may be completed
 S = Subjective, by history
 O = Objective, by standard testing

³ The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp

⁴ If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

⁵ Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.

⁶ Infants born in Iowa should have record of results from newborn hearing screening. <http://www.idph.state.ia.us/iaehdi/default.asp> or toll-free 800-383-3826.

⁷ Iowa Immunization program 1-800-831-6293.

⁸ All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics

⁹ Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk.

Lead program 1-800-972-2026.

¹⁰ TB testing for only at-risk children, Iowa TB program 1-800-383-3826.

Iowa Department of Public Health Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____
 Parent/Guardian: _____ Address: _____ Phone: (____) _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.
 Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant
 A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTp/DT/ Td/Tdap		
Polio IPV/OPV		
Measles, Mumps, Rubella MMR		
Haemophilus influenzae type b Hib		
Hepatitis B		
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"		
Pneumococcal PCV/PPV		

Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal MCV4/PPSV4		
Hepatitis A		
Rotavirus		
Human Papilloma Virus HPV		
Other		

Licensed Child Care Requirements

4 through 5 months 1 dose D/T/P
1 dose Polio
1 dose Hib
1 dose Pneumococcal

12 through 18 months 3 doses D/T/P
 2 doses Polio
 2 doses Hib or 1 dose received at ≥ 15 months of age
 Pneumococcal if received 1 or 2 doses < 12 months of age; any previous doses; or received 1 dose ≥ 12 months of age

6 through 11 months 2 doses D/T/P
 2 doses Polio
 2 doses Hib
 2 doses Pneumococcal

18 through 23 months 4 doses D/T/P
 3 doses Polio
 Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age
 Measles/Rubella ≥ 12 months of age on or after September 15, 1997, or a reliable history of natural disease
 Pneumococcal, or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if not received any previous doses or has received no doses or has received 1 dose ≥ 12 months of age.

24 months and older 23 to 24 months after the 19-23 month Eastern Pneumococcal, 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older 5 doses Diphtheria/Tetanus/Pertussis with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born after September 15, 2000.
 Polio with 1 dose received ≥ 4 years of age if born after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
 Measles/Rubella: the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first dose.
 Hepatitis B: if born on or after July 1, 1994.
 Varicella ≥ 12 months of age if born before September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has a reliable history of natural disease.