**This side of the form is REQUIRED to be filled out!

MT. PLEASANT SCHOOL DISTRICT HEALTH UPDATE

Name of Student_____ Grade____ Building_____

The following information is needed to plan an appropriate program for your child and to be prepared for any emergency situation should one arise. This confidential information will be shared with school staff on a "need to know basis".

MEDICAL HISTORY (check the ones that apply to your current health)

_____ADHD: Medication_____Time taken at home_____Time taken at school_____
_____Asthma
_____Hay Fever
_____Dental Problems: Orthodontic Braces_____Other_____
_____Diabetes
_____Depression
_____Hearing Problems
_____Heart Condition (specify) _____
_____Hemophilia
_____Physical Handicap (specify) _____
_____Seizures
_____Allergies (specify) _____
_____Other (specify)_____

LIST MEDICATION NEEDED FOR ASTHMA _____

Do you use an inhaler at school? YES_____ NO_____

Name of inhaler(s) _____

LIST MEDICATIONS TAKEN AT HOME OR SCHOOL_____

FOR WHAT MEDICAL CONDITION IS THE MEDICATION TAKEN? _____

_____

LIST OPERATIONS SINCE BEGINNING OF LAST SCHOOL YEAR_____

_____

LIST ANY INJURIES OR BROKEN BONES EXPERIENCED SINCE BEGINNING OF LAST SCHOOL YEAR AND DATE_____

DO YOU WEAR CONTACT LENSES? YES_____ NO_____ GLASSES? YES_____NO_____

LAST EYE EXAMINATION (Date)_____ Doctor_____

LAST DENTAL EXAMINATION (Date) _____ Dentist_____

Please see reverse side for medication administration information and Medication Permission Form. Physician and parent/legal guardian signatures are required for prescription medications (including Inhalers and Epi-Pens). Only parent/legal guardian signatures are required for non-prescription medications (Tylenol, Ibuprofen, etc). ***All medication must be supplied to the school by the parent/legal guardian in the original/current container.***

Insurance Provider (Select One):

_____ **Private Insurance**
_____ **Medicaid (Title 19)**
_____ **Hawk-I**
_____ **None**

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

Date of Exam: _____

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: date_____results _____

Sensory Screening:

Vison Assessment:_____

Vision Acuity: Right eye_____Left eye _____

Hearing Assessment: Right ear_____Left ear_____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

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

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

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

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

Medication Name Dosage

☐ Diaper crème:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

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

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 _____
(please attach)

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

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf