Key West
Early Childhood Center

PHYSICAL EXAMINATION FORM

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

Child's Name: _____

Birth Date: _____ **Age Today**: _____

Date of Exam: _____

Height/Length:

Weight:

Head Circumference (Children age 2 yr and under):

Blood Pressure (Start @ Age 3):

Hgb or Hct (Anytime between 6-9 months):

Blood Lead Level (Start @ 12 months):

Sensory Screening

Vision: Right Eye Left Eye

Hearing: Right Ear Left Ear

Typanometry (May attach results)

Developmental Screening[2]

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:

Space is available on back for detailed comments or instructions pertaining to enrollment at child care or preschool

[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.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization

(May attach copy of Iowa Dept of Public Health Immunization Certificate)

Dta/DTP/Td	MMR
Hepatitis B	Pneumococcal
HIB	Varicella
Polio	Other
Influenza	

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 Créme
❒ 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

❒ Other: _____

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***:

May use stamp

Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address Phone