

IKM-Manning Community School District Preschool Health Information

The IKM-Manning preschools are maintained with grants made available with certification levels. These grants and certifications require us to use certain forms provided to the preschool. These forms must be used to complete the health components of maintaining the grants and certifications.

All preschool students are required to have a physical including lead screen results. Please be sure that your health care provider includes results from a lead screen on the physical form. If your child has not had a lead screen in the past and you do not have insurance to pay for one, please notify the school nurse for further assistance. Pages 1 & 2 of the physical form are for the parent/guardian to complete; pages 3 & 4 are for the health care provider to complete.

Dental screening is also required for preschool and may be performed by your health care provider, dentist, dental hygienist, or nurse.

Vision is one of the most used senses for learning in school. Although we do annual screenings at school, a professional vision exam is the best way to detect any visual impairment your child might have. It is recommended that your child have a vision exam. Exams done at the Early Childhood Screening will fulfill the requirement for preschool.

Immunization records are required for each student in preschool. All students need to be current for their age in immunizations.

All necessary forms are attached. If your child's physical is completed on a different form, you will be asked to have your health care provider fill out the required form. A physical is required yearly while your child is in preschool. For example, if they receive one in March prior to preschool, they will also need one in March the year they are in preschool.

FORMS NEED TO BE TURNED IN ON, OR BEFORE, THE 1ST
DAY OF PRESCHOOL. YOUR CHILD WILL NOT BE ABLE TO
ATTEND PRESCHOOL UNTIL FORMS ARE COMPLETED
AND TURNED IN.

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 cannot be reached.</p> <p>Parent/Guardian Signature: _____ Date _____</p> <p>Alternate emergency contact person's name: _____ Phone number: _____</p> <p>Relationship to child: _____ Cellular number: _____</p>			
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:*

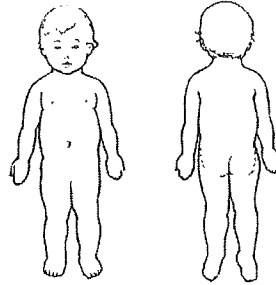
Medication - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

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 (medicine, food, dust, mold, pollen, 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

Space is available on back page 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 a copy of Iowa Department of Public Health Immunization Certificate

DtaP/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
<input type="checkbox"/> Cough medication	
<input type="checkbox"/> Diaper crème:	
<input type="checkbox"/> Fever or Pain reliever:	
<input type="checkbox"/> Sunscreen:	
<input type="checkbox"/> 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

Health Care Provider comments or instructions:

Child's name: _____

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	S	O	O
Hearing ⁶	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations: per Iowa schedule ⁷	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hemaglobinopathy/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 DENTAL SCREENING**

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

No Obvious Problems – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

Requires Dental Care – tooth decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.

Requires Urgent Dental Care – obvious tooth decay¹ is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

¹ Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

² White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.

³ Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
 DDS/DMD RDH MD/DO PA RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) _____ Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider or Recorder*: _____ Date: _____

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • www.idph.state.ia.us/ohds/OralHealth.aspx
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.