Iowa Recommendations for Preventive Pediatric Health Care[2]

Health Provider's Guide	AGE[3]											
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr
History: Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Measurement: Height/Weight	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●			
Blood Pressure										●	●	●
Sensory Screen: Vision	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**O**	**O**	**O**
Hearing	**O**[4]	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**O**	**O**
Developmental: Screen	●	●	●	●	●	●	●	●	●	●	●	●
Complete Unclothed Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hereditary/Metabolic Screen	●[5]											
Hematocrit or Hemoglobin					● →	◆ →	→	→	→	→	→	→
Urinalysis												●
Lead Test						●			●[6]	◆	◆	◆
Cholesterol Screen									◆ →	→	→	→
TB test[7]						◆ →	→	→	→	→	→	→
Immunizations: *per Iowa schedule*[8]	●	●	●	●	●	●	●	●	●	●	●	●
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling												
Tricycle Helmet Counseling												
Sleep Position Counseling	●	●	●	●	●	●						
Nutrition and Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●

Key:
- ● = to be performed
- ◆ = to be performed for at-risk children
- **S** = subjective, by history
- **O** = objective, by standard testing
- → = range in which the task may be completed

[2] For questions about childhood preventive health care go to www.brightfutures.org or www.aap.org or contact the Iowa Healthy Families telephone line 1-800-369-2229.

Each child and family is unique; therefore the Recommendations for Preventive Care are designed for the care of children who are receiving quality care, have no sings of health problems, and are growing and developing satisfactorily.

[3] 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.

[4] All newborns should be screened for congenital hearing impairment, Iowa Newborn Hearing Screening program 1-800-383-3826.

[5] All newborns should receive metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.

[6] Lead testing should be done at 12 and 24 months, Iowa Lead Testing program 1-800-242-2026.

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

[8] Iowa Immunization program 1-800-831-6293.

Iowa School-Age Care – Health Status – Parent Statement

CHILD AND FAMILY INFORMATION Parents complete this page.

Child's name	Child's birthdate	
Name of school	Grade	Telephone number

Parent # 1 name		Parent # 2 name	
Child home address # 1		Child home address # 2	
Home phone # 1	Home email	Home phone # 2	Home email
Where parent # 1 works		Where parent # 2 works	
Work address		Work address	
Work number	Pager number	Work number	Pager number
Cellular number	Work email	Cellular number	Work email

In an emergency, please obtain EMERGENCY MEDICAL or DENTAL CARE if the child care center is unable to contact the parents or guardian. Please contact the following person when a parent or guardian can not be reached.

Name:	***Relationship to child:***	***Phone number:***

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone number	Does your child have health insurance? Yes, company_____ **ID #**_____
Child's dentist's name	Dentist telephone # 1	Does your child have dental insurance? Yes, company_____ **ID #**_____
Dentist's Address	After hours telephone number	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other medical or dental specialist name Type of specialty_____	Telephone number	☐ **Please help us find health or dental insurance.**

Parent or Guardian Signature	**Date**

Iowa School-Age Care – Health Status – Parent Statement

Parents complete this page.

Place a checkmark ✓ in the box ❑ if the sentence applies to your child.

Growth
❑ I am concerned about my child's growth.

Appetite
❑ I am concerned about my child's eating habits.

Rest
❑ My child may need to rest or sleep after school.

Illness/Surgery/Injury
❑ My child had a serious illness, surgery, or injury. Please describe.

Physical Activity
❑ My child must restrict physical activity or needs special equipment. Please describe.

Play with Friends

My child:
❑ Plays well in groups with other children.
❑ Will play only with one or two other children.
❑ Prefers to play alone.
❑ Fights with other children.
❑ I am concerned about my child's play activity with other children.

School and Learning

My child:
❑ Is doing well at school.
❑ Is having difficulty in some classes.
❑ Does not want to go to school.
❑ Frequently misses or is late for school.
❑ I am concerned about how my child is doing in school. Please describe:

Body Health

My child has problems with:
❑ Skin, hair, fingernails or toenails
❑ Eyes\vision, glasses or contact lenses
❑ Ears\hearing, hearing assistive aids or devices, ear aches, tubes in ears
❑ Nose problems, nosebleeds
❑ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
❑ Frequent sore throats or tonsillitis
❑ Breathing, asthma, cough
❑ Heart, heart murmur
❑ Stomach aches or upset stomach
❑ Using toilet, night time wetting
❑ Hard stools, constipation, diarrhea, runny stools
❑ Bones, muscles, movement, pain moving
❑ Mobility, uses assistive equipment
❑ Nervous system, headaches, seizures, or nervous habits (like twitches)
❑ Female monthly periods
❑ Needs special equipment. *Please describe*:

❑ **Medication**
My child takes medication. List meds taken at home, school, or in child care. List the name, time medication taken, and the reason medication prescribed.

❑ **Allergy**
My child has the following allergies (food, medicine, fabric, inhalants, insects, animals, etc.). Please describe.

My child has the following special needs: