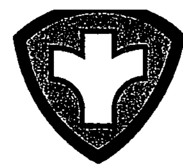
SCOTT COUNTY HEALTH DEPARTMENT
Administrative Center
600 W. 4th Street
Davenport, Iowa 52801-1030
Office: (563) 326-8618 Fax: (563)326-8774
www.scottcountyiowa.com/health



Public Health
Prevent. Promote. Protect.

Dear Parent/Guardian,

Preschool is one of the first steps in your child's educational career and there are many things to consider as you start on this journey. Some of the most important are to make sure your child is healthy, is up to date on his/her immunizations, and has a physical prior to starting preschool. **Iowa Law** *requires* your child to have the following immunizations to be admitted 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 disease)
3 Hib – with the final dose on or after 12 months of age* or 1 Hib dose on or after 15 months of age
4 Pneumococcal (Prevnar, PCV) if received 3 doses under 12 months of age; or 3 doses if received 2 doses under 12 months of age, or 2 doses if received 1 dose under 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.

*Due to a continued nationwide shortage of the Hib vaccine that will be in effect through September 30, 2009, your health care provider may need to follow a different Hib schedule for 2009.

**Pneumococcal vaccine is a new immunization requirement as of January 7, 2009.

An Iowa Certificate of Immunization *must be completed* and 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 completed by a MD, DO, PA or NP. The physical must have been completed within the past 12 months, and updated with a new physical when a year has past. A dental exam and vision exam is highly encouraged, but not required at the preschool age.

Please contact me at (563)326-8618, ext. 8821, if you have questions regarding health information required for preschool enrollment in Iowa. Please contact the Preschool your child is enrolling in for questions related to due dates for forms, etc.

Sincerely,

Janice Telsrow RN, BSN

Janice Telsrow, RN, BSN
Child Care Nurse Consultant

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS complete this page.

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

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 parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.

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 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 #	**NO, we do not have health insurance.** **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

Child Name ____________

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS complete this page.

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.

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 has had a serious illness, surgery, or injury. *Please describe.*

Physical Activity - My child must restrict physical activity. *Please describe.*

Development and Learning

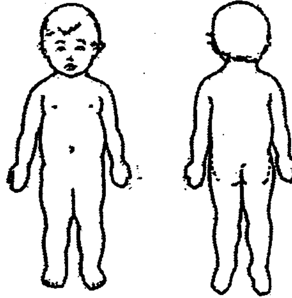
I am concerned about my child's behavior, development, or learning. *Please describe*:

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

Body Health - My child has problems with

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

Map and describe any skin markings



Eyes \ vision, glasses

Ears \ hearing, hearing aides or device, earaches, 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*:

Allergy - My child has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). Please describe.

Parent or child care provider questions or concerns to ask health care provider:

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

[illegible]

Date of Exam:

Height or Length:
Weight
Head Circumference (for children under 2 yr.):
Body Mass Index (for children over 2 yr.):

Blood Pressure (start @ age 3 yr.):
Hgb. or Hct.: (start @ 1 yr.)
Blood Lead Level: (start @ 1 yr.)

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

HEENT
Teeth
Heart
Lungs
Stomach/Abdomen
Genitalia
Extremities, Joints, Muscles, Spine
Skin, Lymph Nodes
Neurological

Sensory and Developmental Screening

Vision Right eye ________ Left eye _________

Hearing Right ear ________ Left ear _________

Tympanometry (attach results)

Developmental Screening results:
Personal-Social
Fine Motor-Adaptive
Language
Gross Motor

Developmental Referral Made Today: ☐Yes ☐No

Birthdate: Age today:

Date of Last **Dental** Exam:

Dental Referral Made Today: ☐Yes ☐No

Vaccines given today:
DtaP/DTP/Td
HEP B
HIB
Influenza
MMR
Pneumococcal
Polio
Varicella
Other

TB testing (for high risk child only)

Referrals made today:

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

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

Medication Name	Dosage
Diaper crème:	
Pain reliever:	
Sunscreen:	
Cough medication	

[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

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROVIDER COMPLETES THIS SECTION – 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 these restrictions***: Describe all restrictions:

Health Provider (may use stamp)
Name: print name: ________________________________

Signature ________________________
Provider's Type (circle) MD DO PA ARNP
Health Care Provider Address:
Health Care Provider Telephone:

Additional Comments from the Health Care Provider

Health Provider's Guide to Iowa Recommendations for Preventive Pediatric Health Care

Health Provider's Guide	AGE[2]											
	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	S	S	S	S	S	S	S	S	S	O	O
Developmental Screening	●	●	●	●	●	●	●	●	●	●	●	●
Complete Unclothed Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hereditary/Metabolic Screen	●[3]											
Hematocrit or Hemoglobin					●	→	◆	→	→	→	→	→
Urinalysis												●
Lead Test						●		◆	●[4]	◆	◆	◆
Cholesterol Screen									◆	→	→	→
TB test[5]						◆	→	→	→	→	→	→
Immunizations: *per Iowa schedule*[6]	●	●	●	●	●	●	●	●	●	●	●	●
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Tricycle Helmet Counseling									●	●	●	●
Sleep Position Counseling	●	●	●	●	●	●						
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●

Key: ● = to be performed
◆ = to be performed for at-risk children
→ = Range in which the task may be completed

S = Subjective, by history
O = Objective, by standard testing

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[2] 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.
[3] All newborns should receive metabolic screening (e.g. Thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.
[4] Lead testing should be done at 12 & 24 months, Testing may be done at additional times for children determined at risk. Lead program 1-800-242-2026.
[5] TB testing for only at-risk children, Iowa TB program 1-800-383-3826. [5]. Iowa Immunization program 1-800-831-6293.

Visual Acuity	At Distance		At Near	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	L		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other ______________________________

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear
☐ Distance vision only
☐ Near vision only
☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) ______________________________

Date______________Signature______________________________

Eye Care Professional:

Please complete this postage paid portion of the Student Vision Card, detach and drop in the mail. This information will be used for data collection purposes only. Thank you!

Patient Grade________ **School**______________ **Town**______________

Patients first visit to an eye doctor?
☐ Yes ☐ No

Vision Correction Recommended?
☐ Yes ☐ No

Eye Health
Please indicate if present

☐ Amblyopia ☐ Strabismus

☐ Refractive error (greater than +/-1.25) ☐ Other ______________________

Thank you!

STUDENT VISION CARD

Student Name ______________________ Date __________

School ______________ Town __________ Grade __________

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card

IOWA OPTOMETRIC ASSOCIATION

Iowa Academy of Ophthalmology

Iowa PTA everychild.onevoice.

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

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POSTAGE WILL BE PAID BY ADDRESSEE

IOWA OPTOMETRIC ASSOCIATION
1454 30TH ST STE 204
WEST DES MOINES IA 50266-9962

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, 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 applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal *MCV4/MPSV4*			
Hepatitis A			
Rotavirus			
HPV			

Licensed Child Care Requirements

2 through 5 months

1 dose Diphtheria/Tetanus/Pertussis
1 dose Polio
1 dose Hib

6 through 14 months

2 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib

15 through 18 months

3 doses Diphtheria/Tetanus/Pertussis
3 doses Polio
3 doses Hib with the final dose ≥ 12 months of age, or 1 dose ≥ 15 months of age
1 dose Measles/Rubella ≥ 12 months of age

19 months and older

3 doses Diphtheria/Tetanus/Pertussis
3 doses Polio
3 doses Hib with the final dose ≥ 12 months of age, or 1 dose ≥ 15 months of age
1 dose Measles/Rubella ≥ 12 months of age
1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease

Elementary/Secondary School Requirements

4 years of age and older

4 doses Diphtheria/Tetanus/Pertussis if born after September 15, 2000; or 3 doses if born on or before September 15, 2000. One of these doses must be received ≥ 4 years of age.
3 doses Polio, with 1 dose ≥ 4 years of age.
2 doses Measles/Rubella or positive antibody test for measles and rubella. First dose ≥ 12 months of age; second dose no less than 28 days after the first dose
3 doses Hepatitis B if born on or after July 1, 1994
1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease