IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent / Guardian complete this page

Please use an X in the □ to statements that apply to your child.

Date of child's last physical exam:________
Date of last dental appointment:__________

Growth
□ I am concerned about child's growth

Appetite
□ I am concerned about child's eating habits

Rest - My Child
□ Needs to rest after school

Illness/Surgury/Injury - My child
□ Had a serious illness, surgery, or injury
Please describe:

Physical Activity - My child
□ Must restrict physical activity or needs special equipment to be active
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.

□ Allergy - My child has allergies (list all allergies: food, medicine, fabric, inahlants, insects, animals, etc)

Child has Epipen, inhaler, or other emergency medication
□ Yes □ No

Child Name________________________

Body Health - My child has problems with:
□ Skin, hair, fingernails or toenails.
Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the photos below.

□ Eyes/vision, glasses or contact lenses
□ Ears/Hearing, hearing assistive aides or device, earache, tubes in ears
□ Nose problems, nosebleeds
□ Mouth, teeth, gums, tongue, sores in mouth or on lips, breath through mouth
□ Frequent sore throats or tonsillitis
□ Breathing problems, asthma, cough
□ Hearth problems or heart murmur
□ Stomach aches or upset stomach
□ Trouble using toilet or wetting accidents
□ Hard stools, constipation, diarrhea, watery stools
□ Bones, muscles, movement, pain when moving
□ Mobility, child uses assistive equipment. Please describe

□ Nervous system, headaches, seizures, or nervous habits
□ Females - difficult monthly periods
□ Other special needs. Please describe:

□Medication - My child takes medication

Medication name	Time Given	Reason

Note to parents: Certificate of Immunization
All child care centers must keep the Certificate of Immunization on site at the child care facility.

Parent Signature: (required)	Date: