

## Infant, Toddler, Preschool Age – Child Health Form

**HEALTH PROFESSIONAL COMPLETE THIS PAGE –**  
OR PROVIDE COPY OF WELL CHILD PHYSICAL

**Date of Exam:** \_\_\_\_\_

Height/Length: \_\_\_\_\_ Weight: \_\_\_\_\_

BMI – starting at age 24 mo. \_\_\_\_\_

Head Circumference- age 2 yr. and under: \_\_\_\_\_

Blood Pressure-start @ age 3 yr.: \_\_\_\_\_

Hgb or Hct- @ 12 mo.: \_\_\_\_\_

Lead Risk Assessment: \_\_\_\_\_

Blood Lead Level: date \_\_\_\_\_ results \_\_\_\_\_

### Sensory Screening:

Vision Assessment: \_\_\_\_\_

Vision Acuity: Right eye \_\_\_\_\_ Left eye \_\_\_\_\_

Hearing Assessment: Right ear \_\_\_\_\_ Left ear \_\_\_\_\_

Tympanometry (may attach results)

### Developmental Screening/Surveillance:

(*n = normal limits*) otherwise describe

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 Date of Dental exam \_\_\_\_\_

Oral Health/Dental Referral Made Today: ☐ Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

### Allergies

Environmental:

Medication:

Food:

Insects:

Other:

**Child Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

### Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

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

Medication Name

Dosage

☐ Diaper crème:

☐ Fever or Pain reliever:

☐ Sunscreen:

☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at

[www.idph.iowa.gov/hcci/products](http://www.idph.iowa.gov/hcci/products)

### Additional Referrals made:

☐

☐

### Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with **NO** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning **with restrictions** (see comments).

☐ The child has a special needs care plan

Type of plan \_\_\_\_\_

(Please complete and give to parent for child care)

Comments:

May use stamp

**Signature** \_\_\_\_\_

Circle the Provider Type: MD ☐ DO ☐ PA ☐ ARNP ☐

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021)  
[https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

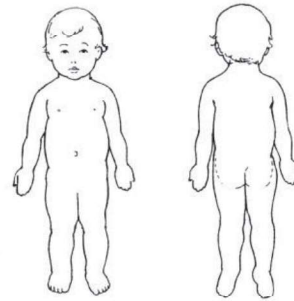
**PARENT/GUARDIAN COMPLETE THIS PAGE****Child's Name:** \_\_\_\_\_

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 health care provider 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:  
☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).Please describe:  
☐ **Special Needs Care Plan** – My child has a special need and needs a care plan for child care. Please discuss with your health care provider.**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 aids 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, spitting-up
- ☐ Using toilet, toilet training, urinating
- ☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
- ☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
- ☐ Needs special equipment.

List equipment:  
☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).Parent/Guardian questions or comments for the health care provider:  

Parent/Guardian Signature

Date:

Recommendations for Preventive Pediatric Health Care – Infant, Toddler, and Preschool Age

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

|                                      |                                                          | INFANCY               |                      |                    |         |      |      |      |      | EARLY CHILDHOOD      |       |        |                      |        |        |     |   |
|--------------------------------------|----------------------------------------------------------|-----------------------|----------------------|--------------------|---------|------|------|------|------|----------------------|-------|--------|----------------------|--------|--------|-----|---|
| AGE <sup>1</sup>                     |                                                          | Prenatal <sup>2</sup> | Newborn <sup>3</sup> | 3-5 d <sup>4</sup> | By 1 mo | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo                | 15 mo | 18 mo  | 24 mo                | 30 mo  | 3 y    | 4 y |   |
| HISTORY:                             | Initial/Interval                                         | ●                     | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    | ●      | ●      | ●   |   |
| MEASUREMENTS:                        | Length/Height and Weight                                 |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    | ●      | ●      | ●   |   |
|                                      | Head Circumference                                       |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    |        |        |     |   |
|                                      | Weight for Length                                        |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      |                      |        |        |     |   |
|                                      | Body Mass Index <sup>5</sup>                             |                       |                      |                    |         |      |      |      |      |                      |       |        | ●                    | ●      | ●      | ●   |   |
|                                      | Blood Pressure <sup>6</sup>                              |                       | *                    | *                  | *       | *    | *    | *    | *    | *                    | *     | *      | *                    | *      | *      | ●   | ● |
| SENSORY SCREENING:                   | Vision <sup>7</sup>                                      |                       | *                    | *                  | *       | *    | *    | *    | *    | *                    | *     | *      | *                    | *      | *      | ●   | ● |
|                                      | Hearing                                                  |                       | ● <sup>8</sup>       | *                  | *       | *    | *    | *    | *    | *                    | *     | *      | *                    | *      | *      | *   | ● |
| DEVELOPMENTAL/BEHAVIORAL ASSESSMENT: |                                                          |                       |                      |                    |         |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | Developmental Screening <sup>9</sup>                     |                       |                      |                    |         |      |      |      | ●    |                      |       | ●      |                      | ●      |        |     |   |
|                                      | Autism Screening <sup>10</sup>                           |                       |                      |                    |         |      |      |      |      |                      |       | ●      | ●                    |        |        |     |   |
|                                      | Developmental Surveillance                               |                       | ●                    | ●                  | ●       | ●    | ●    | ●    |      | ●                    | ●     |        | ●                    |        | ●      | ●   |   |
|                                      | Psychosocial/Behavioral Assessment                       |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    | ●      | ●      | ●   |   |
|                                      | Alcohol and Drug Use Assessment <sup>11</sup>            |                       |                      |                    |         |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | Depression Screening <sup>12</sup>                       |                       |                      |                    |         |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | PHYSICAL EXAMINATION <sup>13</sup>                       |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    | ●      | ●      | ●   |   |
| PROCEDURES <sup>14</sup> :           | Newborn Blood Screening <sup>15</sup>                    |                       | ←                    | ●                  | →       |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | Critical Congenital Heart Defect Screening <sup>16</sup> |                       | ●                    |                    |         |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | Immunization <sup>17</sup>                               |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    | ●      | ●      | ●   |   |
|                                      | Hematocrit or Hemoglobin <sup>18</sup>                   |                       |                      |                    |         |      | *    |      |      | ●                    | *     | *      | *                    | *      | *      | *   |   |
|                                      | Lead Screening <sup>19</sup>                             |                       |                      |                    |         |      |      | *    | *    | ● or * <sup>20</sup> |       | *      | ● or * <sup>20</sup> |        | *      | *   |   |
|                                      | Tuberculosis Testing <sup>21</sup>                       |                       |                      |                    | *       |      |      | *    |      | *                    |       |        | *                    |        | *      | *   |   |
|                                      | Dyslipidemia Screening <sup>22</sup>                     |                       |                      |                    |         |      |      |      |      |                      |       |        | *                    |        |        | *   |   |
|                                      | STI/HIV Screening <sup>23</sup>                          |                       |                      |                    |         |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | Cervical Dysplasia Screening <sup>24</sup>               |                       |                      |                    |         |      |      |      |      |                      |       |        |                      |        |        |     |   |
|                                      | ORAL HEALTH <sup>25</sup>                                |                       |                      |                    |         |      |      | *    | *    | ● or *               |       | ● or * | ● or *               | ● or * | ● or * | ●   |   |
|                                      | Fluoride Varnish <sup>26</sup>                           |                       |                      |                    |         |      |      | ←    |      |                      |       | ●      |                      |        |        |     |   |
|                                      | ANTICIPATORY GUIDANCE                                    |                       | ●                    | ●                  | ●       | ●    | ●    | ●    | ●    | ●                    | ●     | ●      | ●                    | ●      | ●      | ●   | ● |

KEY: ● = to be performed      ● or \* = risk assessment to be performed with appropriate action to follow, if positive      ← ● → = range during which a service may be provided

## Footnotes for Recommendations for Preventive Pediatric Health Care

1. 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.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement “The Prenatal Visit” (<http://pediatrics.aappublications.org/content/124/4/1227.full>).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement “Breastfeeding and the Use of Human Milk” (<http://pediatrics.aappublications.org/content/129/3/e827.full>). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement “Hospital Stay for Healthy Term Newborns” (<http://pediatrics.aappublications.org/content/125/2/405.full>).
5. Screen, per the 2007 AAP statement “Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report” ([http://pediatrics.aappublications.org/content/120/Supplement\\_4/S164.full](http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full)).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, “Visual System Assessment in Infants, Children, and Young Adults by Pediatricians” (<http://pediatrics.aappublications.org/content/137/1/1.51>) and “Procedures for Evaluation of the Visual System by Pediatricians” (<http://pediatrics.aappublications.org/content/137/1/1.52>).
8. All newborns should be screened, per the AAP statement “Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs” (<http://pediatrics.aappublications.org/content/120/4/898.full>).
9. See 2006 AAP statement “Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening” (<http://pediatrics.aappublications.org/content/118/1/405.full>).
10. Screening should occur per the 2007 AAP statement “Identification and Evaluation of Children with Autism Spectrum Disorders” (<http://pediatrics.aappublications.org/content/120/5/1183.full>).
11. A recommended screening tool is available at <http://www.ceasar-boston.org/CRAFFT/index.php>.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at [http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH\\_ScreeningChart.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf).
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement “Use of Chaperones During the Physical Examination of the Pediatric Patient” (<http://pediatrics.aappublications.org/content/127/5/991.full>).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by The Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdorders.pdf>), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement “Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease” (<http://pediatrics.aappublications.org/content/129/1/190.full>).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: <http://aapredbook.aappublications.org/site/resources/izschedules.xhtml>. Every visit should be an opportunity to update and complete a child’s immunizations.
18. See 2010 AAP statement “Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)” (<http://pediatrics.aappublications.org/content/126/5/1040.full>).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” ([http://www.cdc.gov/nceh/lead/ACCLPP/Final\\_Document\\_030712.pdf](http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Book: Report of the Committee on Infectious Diseases. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, “Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents” ([http://www.nhlbi.nih.gov/guidelines/cvd\\_ped/index.htm](http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm)).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP Red Book: Report of the Committee on Infectious Diseases. Additionally, all adolescents should be screened for HIV according to the AAP statement (<http://pediatrics.aappublications.org/content/128/5/1023.full>) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspsscerv.htm>). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement “Gynecologic Examination for Adolescents in the Pediatric Office Setting” (<http://pediatrics.aappublications.org/content/126/3/583.full>).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement “Oral Health Risk Assessment Timing and Establishment of the Dental Home” (<http://pediatrics.aappublications.org/content/111/5/1113.full>), 2014 clinical report “Fluoride Use in Caries Prevention in the Primary Care Setting” (<http://pediatrics.aappublications.org/content/134/3/626>), and 2014 AAP statement “Maintaining and Improving the Oral Health of Young Children” (<http://pediatrics.aappublications.org/content/134/6/1224.full>).
26. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspstdnch.htm>). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report “Fluoride Use in Caries Prevention in the Primary Care Setting” (<http://pediatrics.aappublications.org/content/134/3/626>).