IOWA SCHOOL-AGE CARE – HEALTH STATUS – PARENT STATEMENT

Parent/Guardian complete this page

Child's Name:_____

Date of child's last physical exam: _____
Date of last dental appointment: _____

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

I am concerned about

- ☐ My child's growth
- ☐ My child's eating habits
- ☐ My child's play activity with other children
- ☐ How my child is doing in 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 to be active.

Please describe:

☐ **Allergy** – My child has allergies (list all allergies: food, medicine, fabrics, inhalants, insects, animals, etc.):

Child has Epipen, inhaler, or other emergency medication.

☐ Yes ☐ No

☐ **Medication**[1] – My child takes medication.

Medications Name | Time Given | Reason for giving medication

Note to parents: **Certificate of Immunization**
School-owned and operated child care programs located on school property may file/store your child's Certificate of Immunization in the school office or in the school nurse's office. All other school-age child care programs must keep the Certificate of Immunization o-site at the childcare facility.

Body Health – My child has problems with:

- ☐ Skin, hair, fingernails, or toenails.
- ☐ 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, breaths through mouth
- ☐ Frequent sore throats or tonsillitis
- ☐ Breathing problems, asthma, cough
- ☐ Heart 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
- ☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
- ☐ Females – difficult monthly periods
- ☐ Other special needs.

If any of the above are checked please describe:

Disability:

Does the child have a disability? ☐ No ☐ Yes

If yes, describe the major life activity or functions affected by the disability (see link for definitions of disability http://www.eeoc.gov/laws/statutes/adaaa_info.cfm)

If yes, explain why the disability restricts the child's daily activity:

If no, identify the medical condition that does not rise to the level of a disability:

☐ *By checking this box and typing your name in the signature field, you are stating that the information you've provided herein is true and correct to the best of your knowledge.*

Parent Signature: _____ Date: _____
(required)

1 Parents: Please review the child care program's policies about the use of medication at child care.