Tri-County Child and Family Development Council

P.O. Box 1050 Waterloo, Iowa 50704
Fax: 319-235-0384 Phone: 319-235-0383

Health Maintenance Exams

Child's Name_____

Birthdate:_____

Date of Exam_____

Height_____ Weight_____

Blood Pressure_____

Hgb or Hct _____

Blood Lead Level Drawn_____ Results_____

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear_____ Left ear _____

Developmental Screening:

Developmental screening results:

Autism screening results:

Physchosocial/behavioral results:

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

HEENT

Oral/Teeth

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

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed comments or instructions pertaining to enrollment at preschool.

Physical exam is current for one year after date of exam.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach a copy of Iowa Department of Public Health Immunization Certificate.

Medication: If medications are to be given at school, parent will need to sign a medication form.

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care:

Health Provider Assessment Statement

☐ The child may participate in developmentally appropriate preschool with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate preschool ***with the following restrictions:***

Please see the back side for additional comments and the Iowa EPSDT Care for Kids Health Maintenance Recommendations.

May use stamp

Signature _____

Circle the Provider Credential Type:
MD DO PA ARNP

Health Care Provider

Child's Name & D.O.B _____

Comments or Instructions

Iowa **EPSDT Care for Kids** Health Maintenance Recommendations

KEY

- ● To be performed
- ● To be performed at all visits
- ◻ Screen at least once during time period indicated
- S Subjective, by history;
- O Objective, by standard testing method
- ✲ Assess risk

		AGE																				
		Infancy							Early Childhood						Mid. Childhood				Adolescence				
		2-3[1] days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	30 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
History	Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Physical exam	As part of each visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Measurements	Weight/length: each visit through 18 mo; BMI each visit 24 mo and older	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Head circumference	●	●	●	●	●	●	●	●	●	●												
	Blood pressure	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	●	●	●	●	●	●	●	●	●	●	●
Nutrition/Obesity prevention	Assess/educate	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Oral health	Assessment at 6 and 9 mo and until a dental home is established. Referral to dental home by 12 mo. Ask about dental home at 3 and 6 yr					●	●	●			●	●		●		●							
Developmental and behavioral assessment	Developmental surveillance	●	●	●	●	●		●	●			●	●	●	●	●	●	●	●	●	●	●	●
	Developmental screening: 9, 18, 24 or 30 mo						●			●	◻												
	Autism screening: 18 & 24 mo									●	●												
	Psychosocial/behavioral assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
	Alcohol and drug use assessment																		✲	✲	✲	✲	✲
Sensory screening	Vision	S O	S S	S S	S S	S S	S S	S S	S S	S S	S S	S S	O S	O O	O O	O O	O O	O O	O S	◻ S	S	O S	S S
	Hearing																						
Immunization	Perform an immunization review at each visit; administer immunizations at recommended ages, or as needed	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory guidance	Provided at every visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES																							
Lipid screening											✲			✲	✲	✲	✲	✲	✲	✲	✲	◻	
Hemoglobin/ hematocrit	Perform once between 9-month and 12-month visits for children at risk; also annually for adolescents if risk factors are present				✲		◻			✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲
Lead Screening	Assess and screen children at 12 mo. and 2 years of age; Assess and test high-risk children at 18 months, 3,4, 5 and 6 years.					✲	✲	●		✲	●		✲	✲	✲								
Metabolic screening	The Iowa Newborn Screening Program tests for hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, congenital adrenal hyperplasia, plus expanded metabolic screening.	◻																					
Sexually transmitted infections	Screen as appropriate. People with a history of, or at risk for, STIs should be tested for chlamydia and gonorrhea.																		✲	✲	✲	✲	✲
Cervical Dysplasia Screening	Pap test at age 21, unless immunosupression or HIV																		✲	✲	✲	✲	●
Tuberculin test	Annual testing is recommended for high risk groups, which include household members of persons with TB or others at risk for close contact with the disease; recent immigrants or refugees from countries where TB is common (e.g., Asia, Africa, Latin America, Pacific islands and former Soviet Union); migrant workers; residents of correctional institutions or homeless shelters; persons with certain underlying medical disorders. Children with HIV and incarcerated adolescents should be screened yearly.	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲	✲

[1] For newborns discharged within 24 hours or less after delivery.

✲ **Medicaid recommends and will reimburse for annual visits for older children and adolescents, but does not yet require them.**

9/11

Physical exam is current for one year after date of exam.

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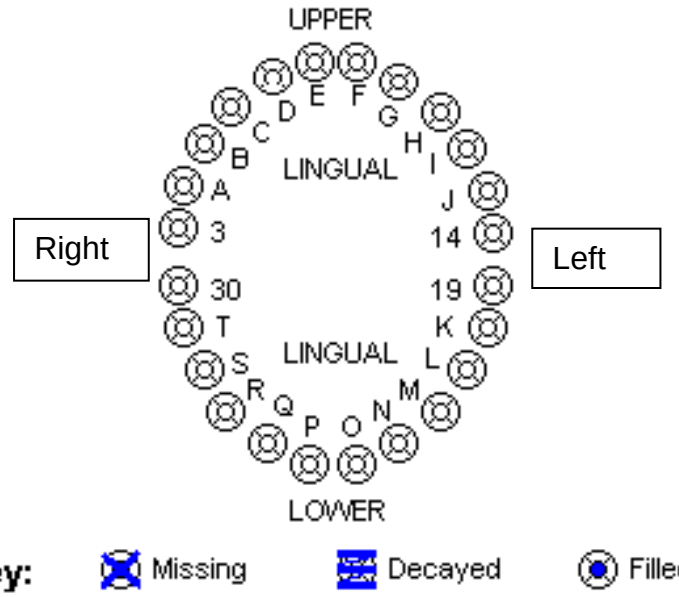
Oral Health Assessment

Date Completed: ____/____/_____ **Child's Name:** _____ **DOB**: _____

Provider Setting: ☐ Doctor/Clinic ☐ School/Center ☐ Other: Specify _____



Comments:

Gum Condition:
☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Preventative Treatment Received:
☐ Cleaning ☐ Oral Hygiene Instruction ☐ Fluoride Application ☐ Other _____

Treatment Needed:
☐ No Needs ☐ Restoration ☐ Extraction ☐ Pulp Therapy ☐ Other: _____

Treatment Received:
☐ Restoration ☐ Extraction ☐ Pulp Therapy ☐ Other: _____

Provider Signature: _____ **Date:** _____

Print Provider Name: _____

This card should be signed and returned to the Head Start Administration office within 7 Days of your child's exam.

Revised 7/06