

**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:

Psychosocial/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  
Comments or Instructions

Child's Name & D.O.B \_\_\_\_\_

### Iowa EPSDT Care for Kids Health Maintenance Recommendations

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

		AGE														See below *									
		Infancy					Early Childhood				Mid Childhood				Adolescence										
		2-3 <sup>1</sup> 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 Hearing	S	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	O	O	☐	O	S	O	S
Immunization	Perform an immunization review at each visit; administer immunizations at recommended ages, or as needed	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anticipatory guidance	Provided at every visit	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
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 immunosuppression 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.	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆	☆

<sup>1</sup> 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.

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

# Tri-County Child & Family Development Council, Inc.

P.O. Box 1050

Waterloo, IA 50704

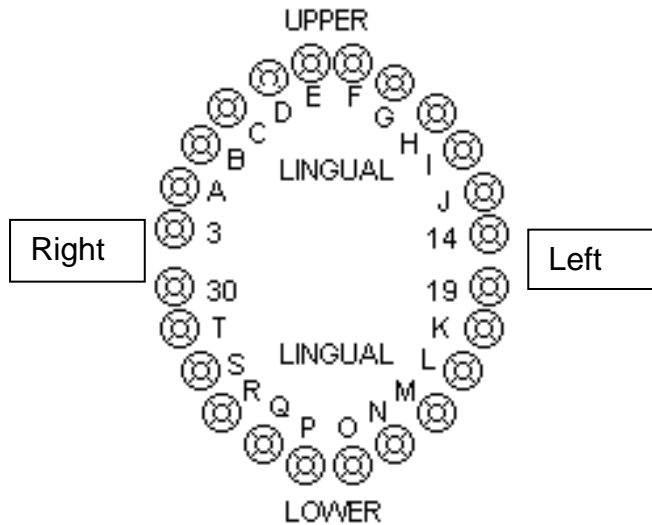
Phone: (319) 235-0383 Fax: (319) 235-0384

## Oral Health Assessment

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Provider Setting:  Doctor/Clinic  School/Center  Other: Specify \_\_\_\_\_



Comments:

Key:  Missing  Decayed  Filled

**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.