PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Please use an **X** in the box ☐ for 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/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:

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.

Please describe:

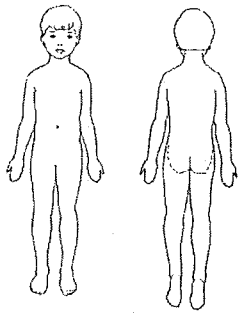
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school.

Please describe:

☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.).
List allergies:

☐ **Body Health** - My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars.
Draw below where these marks/scars are located.



☐ 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
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or 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.

Please describe:

☐ **Medication**[2] - My child takes medication.
Medication Name Time Given Reason for giving medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at https://hhs.iowa.gov/hcci/products

☐ **Special Needs Care Plan** - My child has a special need and a care plan for child care. Please discuss with your health care provider.

Parent/Guardian Signature (required) _____ Date: _____

[2] Please review the child care program's/school policies about the use of medication.