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.

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

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

Health Care Provider Comments or Instructions

Child's Name & D.O.B ___________________________

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

KEY

- ● To be performed
- ✪ (boxed) Screen at least once during time period indicated
- S Subjective, by history
- O Objective, by standard testing method
- * Assess risk

	AGE																						✶See below
	Infancy								Early Childhood						Mid.Childhood				Adolescence				
	New-born	2-5 days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	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 every visit. Referral to dental home within 6 mo. of eruption of first tooth or by 12 mo. Ask about dental home status at every visit.	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental and behavioral assessment Caregiver Deperession Screening	*	*	●	●	*	●	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Developmental surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Developmental screening: 9, 18, 24 or 30 mo							●			●	✪												
Autism screening: 18 & 24 mo										●	●												
Psychosocial/behavioral assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and drug use assessment																			*	*	*	*	*
Adolescent Depression Screening																			●	●	●	●	●
Sensory screening Vision	S	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	O	O	✪		O	S
Hearing	O	S	S	S	S	S	S	S	S	S	S	S	S	O	O	O	O	O	S	S	S	S	S
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**											*			*		*	*	●	*	*	*		✪
PROCEDURES: **Hemoglobin/ hematocrit**					*			●	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
PROCEDURES: **Lead Testing**						*	*	●		*	●		*	*	*	*							
PROCEDURES: **Newborn screening** Blood, hearing, critical congenital heart disease	●																						
PROCEDURES: **Sexually transmitted infections/HIV screening**																			*	*	*	*	*
PROCEDURES: **Cervical Dysplasia Screening**																							●
PROCEDURES: **Tuberculosis testing**			*			*		*			*		*	*	*	*	*	*	*	*	*	*	*

✶**Medicaid recommends a 30-month visit and annual visits for older children and adolescents, but does not require them.**

9/14

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

Updated 1/2015