Postville Childcare Services, Inc.

WELL CHILD CHECK

PO Box 402 Postville, IA 52162
Phone: 563-864-7669 Fax: 563-864-7668

Date of Well Child Check: ______________

Child's Name: ______________________________ **Birthdate:** ___________ **Current Age:** _____

Following the screening/surveillance per the EPSDT schedule:

***Height:** ________ ***Weight:** ________ ***BMI:** _________ ***Blood Pressure:** _________

***Lead:** Date ________ Results ______ ***Hemoglobin/Hematocrit:** Date ________ Results ______

***Are there any concerns regarding this child's development and/or behavior?** □ **Yes** □ **No**

***If yes, what is the concern?** ____

***Is a referral being made and to whom?** □ **Yes** □ **No** ______________________________

***Vision Screening:** R 20/____ L 20/____ ***Glasses** □ Yes □ No ***Hearing Risk:** □ None □ Low □ High

Exam Results: Tubes: □ Yes □ No

N	ABN	NA		COMMENTS
			General Appearance	
			Behavior/Interaction with Family	
			Skin	
			Head/Scalp	
			Ears	
			Eyes	
			Nose	
			Mouth/Throat	
			Teeth/Oral (Was a referral made? □ Yes □ No)	
			Neck	
			Back/Chest	
			Lungs	
			Heart	
			Abdomen	
			Genitalia	
			Musculoskeletal	
			Neurologic	

Immunizations: ***Please attach a copy of current immunization record on the Iowa Dept of Public Health Form including a nurse or physician signature. (This is the only acceptable form required by licensing)***

Allergies: □ No □ Yes ______________________________

Prescribed Medications: □ No □ Yes ____________________

Health Professional authorizes the use of the following medication:

□ diaper cream dosage: ____________
□ pain/fever reducer dosage: ____________
□ sunscreen dosage: ____________
□ bug spray dosage: ____________
□ other __________ dosage: ____________

Health Concerns/Diagnosis: ____

Referrals: ____

□ This child may participate in a developmentally appropriate childcare program with **no** health related restrictions.

□ This child may participate in a developmentally appropriate childcare program **with the following restrictions:**

Health Care Provider Signature: ______________________ MD/DO/PA/ARNP Date: _________