PRESCHOOL STUDENT HEALTH HISTORY
IOWA CITY COMMUNITY SCHOOL DISTRICT

TO PARENTS:
A health examination by your child’s primary health care provider is important to your child’s health and important for the school to be able to adapt its program to individual needs. Please have your child examined before entering school and periodically thereafter according to the recommendations of your child’s primary health care provider. Parents, please fill out this side of the form. Have your child’s primary health care provider complete the back side of the form or health care provider may choose to provide their own forms.

THIS SIDE TO BE COMPLETED BY PARENT:

____________________  ___________________  ______________________________________  _____
Child’s Last Name       Child’s First Name       Address                                    Birthdate

__________________________  ___________________  __________________
Child’s Physician/ NP/ PA       Phone            Hospital Preference

Child’s Dentist

____________________________  __________________
Phone

Does your child have any of the following, or does he/she have a history of any of the following? If answer is yes, please explain in detail below:

YES  NO
1. ___ ___ Asthma
2. ___ ___ Seizures
3. ___ ___ Diabetes
4. ___ ___ Heart problems
5. ___ ___ Depression/Anxiety
6. ___ ___ ADD/ADHD
7. ___ ___ Allergies to food, medication, bee stings, dust/pollen
8. ___ ___ Headaches
9. ___ ___ Vision problems  wears glasses_______  wears contacts_____
10. ___ ___ Hearing problems  left ear_____  right ear_____  hearing aid(s)___________
11. ___ ___ Eating problems/dietary considerations
12. ___ ___ Bowel/bladder problem

Details of health condition(s) to which you answered “yes” above: __________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

IT IS THE PARENT’S RESPONSIBILITY TO PROVIDE A COMPLETED IMMUNIZATION CERTIFICATE FOR EACH CHILD UPON ENTRY INTO SCHOOL!
# PRESCHOOL STUDENT HEALTH STATUS
## IOWA CITY COMMUNITY SCHOOL DISTRICT

**NAME _______________________________**  
**BIRTHDATE_____/_____/_____**  
**DATE OF EXAMINATION___ /_____/_____**  

**THIS SIDE TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, or PHYSICIAN ASSISTANT:**

I hereby certify that the above named child was examined by me within the past twelve months and is able to participate in the school program of the Iowa City Community School District.  

**YES [   ] NO [   ]**

<table>
<thead>
<tr>
<th>Height______________</th>
<th>Weight_____________</th>
<th>Blood Pressure_______</th>
<th>Hearing________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision – __________</td>
<td>(Please complete Iowa Certificate of Vision Screening)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONCERNS/RESTRICTIONS:**

1. **Does this child have any vision, hearing, or speech concerns that the school should be aware of and/or make accommodations for?**  
   **YES [   ] NO [   ]**  
   **Needs further evaluation?**  
   **YES [   ] NO [   ]**

2. **Does this child have any condition which may affect the child's participation in:**  
   **YES [   ] NO [   ]**  
   **Classroom activities?**  
   **Yes [   ] NO [   ]**  
   **Physical education/physical activities?**  
   **Yes [   ] NO [   ]**

3. **Does this child have any condition which may result in a classroom emergency, i.e. asthma, seizures, fainting, diabetes, etc.?**  
   **YES [   ] NO [   ]**  
   **If yes, please describe:**

4. **Is there any emotional, mental, or physical condition for which this child should remain under periodic medical observation?**  
   **YES [   ] NO [   ]**  
   **Needs further evaluation?**  
   **YES [   ] NO [   ]**

5. **Teeth and gums:**  
   **_____ No obvious problems**  
   **_____ Requires dental care**  
   **_____ Requires urgent dental care**  
   **Referral made to:**

6. **Are immunizations up to date?**  
   **YES [   ] NO [   ]**  
   **If no, please identify missing immunizations and plans for bringing up to date:**

7. **Has this child received a blood lead screening test, as required by Iowa law?**  
   **YES [   ] NO [   ]**  
   **If so, please give the date and result of the lead screening, and plan for follow up if needed:**

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**Physician, NP, or PA Name (Printed) ___________**  
**Phone ___________**  
**Physician, NP, or PA Signature ___________**  
**Today’s Date ___________**