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 [ ]

Height_____ Weight_____ Blood Pressure_____ Hearing_____
Vision – _____(Please complete Iowa Certificate of Vision Screening)

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 [ ]	If yes or further evaluation is needed, please describe:
2. Does this child have any condition which may affect the child's participation in: Classroom activities? YES [ ] NO [ ] Physical education/physical activities? YES [ ] NO [ ]	If yes, please describe:
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 [ ]	If yes or further evaluation is needed, please describe:
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:

_____ _____ _____ _____
Physician, NP, or PA Name (Printed) Phone Physician, NP, or PA Signature Today's Date