Formulario de salud para niños en edad escolar/Declaración de salud de los padres

Padre, madre o tutor: completar las páginas 1 y 2.

Nombre del niño	Fecha de nac. del niño	Nombre de la escuel Grado _____ N.º de teléfono de la escuela
Nombre deL padre/madre/tutor n.º1	Nombre de padre/madre/tutor n.º 2	
Dirección del niño n.º 1		Teléfono n.º 1
Dirección del niño n.º 2		Teléfono n.º 2
Lugar de trabajo del padre/madre/tutor n.º 1	Dirección del trabajo	N.º de teléfono Trabajo Celular Particular
Lugar de trabajo del padre/madre/tutor n.º 2	Dirección del trabajo	N.º de teléfono Trabajo Celular Particular

En caso de emergencia médica, el proveedor de cuidados de guardería está autorizado a obtener ATENCIÓN DE EMERGENCIA MÉDICA U ODONTOLÓGICA, incluso si el centro de guardería no pudiera comunicarse inmediatamente con el padre, la madre o el tutor. SÍ NO

Durante una emergencia, el proveedor de cuidados de guardería está autorizado a comunicarse con la persona mencionada a continuación cuando no pudiera comunicarse con el padre, la madre o el tutor.

Firma del padre/de la madre/del tutor:_____**Fecha** _____

Nombre de la persona de contacto de emergencia alternativo: **N.º de teléfono** _____

Relación con el niño: **N.º de celular** _____

Nombre del **médico** del niño ☐ El niño no tiene un médico	N.º de teléfono 1 del médico	**Hospital preferido** N.º de teléfono_____
Dirección del médico	Teléfono fuera del horario	¿El niño tiene seguro de salud? ☐ SÍ ☐ NO Compañía _____ **N.º de ID**
Nombre del **dentista** del niño ☐ El niño no tiene un dentista	N.º de teléfono 1 del dentista	¿Su hijo tiene seguro odontológico? ☐ SÍ ☐ NO Compañía _____ **N.º de ID**
Dirección del dentista	Teléfono fuera del horario	☐ **AYÚDENOS a buscar un médico o dentista para la familia** ☐ **AYÚDENOS a obtener seguro de salud u odontológico**
Nombre de otro especialista de atención médica o de salud mental **Tipo de especialidad**	N.º de teléfono	

Nombre del niño:

Formulario de salud para niños en edad escolar/Declaración de salud de los padres

Padre/madre/tutor complete esta página

Nombre del niño: _____

Marque con una **X** la casilla ☐ de las afirmaciones que se apliquen a su hijo.

Fecha del último examen físico del niño: _____
Fecha de la última consulta odontológica: _____

Crecimiento
☐ Me preocupa el crecimiento del niño.

Apetito
☐ Me preocupa la alimentación/los hábitos de alimentación o el apetito del niño.

Descanso
☐ Mi hijo necesita descansar después de la escuela.

Enfermedad/cirugía/lesión
☐ Mi hijo tuvo una enfermedad, cirugía o lesión grave.
Describa:

Actividad física - Mi hijo
☐ Debe restringir la actividad física o necesita un equipo especial para realizar actividad. Describa:

Juego con amigos - Mi hijo
☐ Juega bien en grupos con otros niños.
☐ Jugará solo con uno o dos niños. Prefiere
☐ jugar solo.
☐ Pelea con otros niños.
☐ Me preocupa la actividad de juego de mi hijo con otros niños.

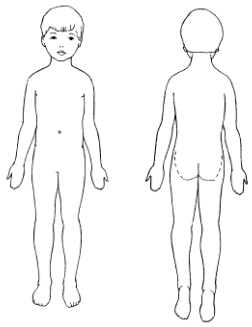
Escuela y aprendizaje - A mi hijo
☐ le va bien en la escuela.
☐ Tiene dificultades en algunas clases.
☐ No quiere ir a la escuela.
☐ Falta o llega tarde con frecuencia a la escuela.
☐ Me preocupa cómo le está yendo a mi hijo en la escuela. Describa:

☐ **Alergia** - Mi hijo tiene alergias (a medicamentos, alimentos, polvo, moho, polen, insectos, animales, etc.). Haga una lista de las alergias:

☐ **Plan de atención de necesidades especiales** – Mi hijo tiene un plan de atención de necesidades especiales (IEP, Plan de acción para el asma, Plan de acción para alergias alimentarias, etc.). Hable al respecto con su proveedor de atención médica.

Salud corporal - Mi hijo tiene problemas con

☐ Piel, pelo, uñas de los dedos de las manos o de los pies. Describa marcas en la piel, marcas de nacimiento o cicatrices. Usando el dibujo que aparece a continuación, muéstrenos dónde se encuentran estas marcas en la piel.



☐ Ojos/visión, anteojos o lentes de contacto
☐ Oídos/audición, audífonos, dolores de oído, tubos en los oídos
☐ Problemas nasales, hemorragias nasales
☐ Boca, dientes, encías, lengua, llagas en la boca o en los labios, respiración bucal
☐ Dolores de garganta o amigdalitis frecuentes
☐ Problemas respiratorios, asma, tos, crup
☐ Problemas cardíacos o soplo cardíaco
☐ Dolores de estómago, malestar estomacal
☐ Problemas para ir al baño o enuresis
☐ Heces duras, estreñimiento, diarrea, heces acuosas
☐ Huesos, músculos, movimiento, dolor al moverse
☐ Movilidad, el niño usa equipo de asistencia
☐ Sistema nervioso, dolores de cabeza, convulsiones o hábitos nerviosos (como tics o movimientos nerviosos)
☐ Niñas – períodos menstruales difíciles
☐ Otras necesidades especiales. Describa:

☐ **Medicamentos** [1] - Mi hijo toma medicamentos.

Nombre del medicamento	Hora de administración	Motivo de administración

El niño tiene una pluma de epinefrina (Epipen), un inhalador u otro medicamento de emergencia.
☐ Sí ☐ No

Firma del padre/madre/tutor: (obligatorio) **Fecha:**

[1] Padres: Revise las políticas del programa de cuidados de guardería acerca del uso de medicamentos en la guardería.

School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE

Date of Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____,

☐There are weight concerns

☐Referral made to _____

Blood Pressure: _____

Laboratory Screening:

Blood Lead Level: Date_____ ☐ venous ☐ capillary (for child under age 6 yr.) Results _____

Hgb. / Hct: _____

Urinalysis: _____

TB testing (high risk child only) _____

Sensory Screening

Vision Acuity: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

Exam Results *(N = normal limits) otherwise describe*

Skin:

HEENT:

Teeth/Oral health:

Date of Dentist Exam: _____ or ☐ none to date.

Dental Referral Made Today ☐ Yes ☐ No

Heart:

Lungs:

Stomach/Abdomen:

Genitalia:

Extremities, Joints, Muscles, Spine:

Neurological:

Psychosocial/Behavioral Assessment (Depression screening starting at age 11)

Allergies

Environmental
Medication
Food
Insects
Other

Health Care Provider Comments:

Child Name: _____

Date of Birth: _____ Age: _____

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious

Health provider authorizes the child to receive the following medications while at child care or school
(Including *over-the-counter* and *prescribed*)

Medication Name	Dosage
☐Fever/Pain reliever:	
☐Sunscreen:	
☐Cough medication:	
☐Other - list all	

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

☐ Referred to hawk-i today **1-800-257-8563**

☐ Other: _____

Health Provider Statement:

☐The child may **fully participate** with ***NO*** health-related restrictions.

☐The child has the following **health-related restrictions** to participation: (please specify)

☐ The child has a special needs care plan
Type of plan _____
(please attach)

Signature _____
Provider Type (circle) MD DO PA ARNP

Address: May use stamp Telephone:

The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015)
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in *Bright Futures* guidelines (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal[2]**	**Newborn[3]**	**3-5 d[4]**	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																	
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																					
Weight for Length		●	●	●	●	●	●	●	●	●	●																						
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																	
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																	
Developmental Screening[9]								●			●		●																				
Autism Screening[10]											●	●																					
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[12]																						●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]																																	
Newborn Blood Screening[15]		←—	●	—→																													
Critical Congenital Heart Defect Screening[16]		●																															
Immunization[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[19]							★	★	● or ★[20]		★	● or ★[20]		★	★	★	★																
Tuberculosis Testing[21]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[22]												★			★		★		★	←—	●	—→	★	★	★	★	★	★	←—	●	—→		
STI/HIV Screening[23]																						★	★	★	★	★	←—	●	—→	★	★	★
Cervical Dysplasia Screening[24]																																●
ORAL HEALTH[25]							★	★	● or ★		● or ★	● or ★	● or ★	●			●															
Fluoride Varnish[26]							←—				●	—→																				
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in the 2012 AAP statement "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborn infants discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.51) and "Procedures for Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/1.52).
8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. See 2006 AAP statement "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
10. Screening should occur per the 2007 AAP statement "Identification and Evaluation of Children with Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
11. A recommended screening tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
12. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
13. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
14. These may be modified, depending on entry point into schedule and individual need.
15. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.
16. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per the 2011 AAP statement "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
17. Schedules, per the AAP Committee on Infectious Diseases, are available at: http://aapredbook.aappublications.org/site/resources/izschedules.xhtml. Every visit should be an opportunity to update and complete a child's immunizations.
18. See 2010 AAP statement "Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
19. For children at risk of lead exposure, see the 2012 CDC Advisory Committee on Childhood Lead Poisoning Prevention statement "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
20. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
23. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the *AAP Red Book: Report of the Committee on Infectious Diseases*. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://pediatrics.aappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
24. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
25. Assess if the child has a dental home. If no dental home is identified, perform a risk assessment (http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.aappublications.org/content/111/5/1113.full), 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children (http://pediatrics.aappublications.org/content/134/6/1224.full)."
26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

KEY ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←— ● —→ = range during which a service may be provided