Community Services CSNT of Northeast Texas, Inc.

Head Start
"Building partnerships, changing lives"

HEAD START ENROLLMENT HEALTH HISTORY FORM

Medication

Is your child currently taking any medication? ☐Yes ☐No
If yes, what medication and when does the child receive the medication? ______________________________

____

if your child receives medication at school, medication administration forms need to be completed by doctor

Medical

Is your child current with well-child exams? ☐Yes ☐No Date of Last Exam: __________________________
Is your child being treated by a physician for any of the following conditions?

- ☐ Anemia/Sickle Cell
- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures
- ☐ Cardiac Disorders
- ☐ Vision Problems(glasses/difficulty seeing/headaches)
- ☐ Hearing Problems (difficulty hearing/tubes/earaches
- ☐ High Lead Levels

Please specify: ____

____

Does your child have any of the following allergies?

- ☐ Insect Stings/Bites
- ☐ Medication:____________________________
- ☐ Poison Ivy/Oak

Does your child require an EPI-PEN? ☐ Yes ☐ No

If your child has an allergy, an ALLERGY ACTION PLAN will need to be completed by doctor

Does your child have any of the following problems?

- ☐ Seasonal Allergies: ______________________
- ☐ Eczema, hives, other skin problems
- ☐ Bed wetting
- ☐ Daytime wetting
- ☐ Frequent diarrhea
- ☐ Frequent urination
- ☐ Frequent constipation
- ☐ Painful urination
- ☐ Wears diapers/training pants
- ☐ Frequent indigestion
- ☐ Frequent stomachaches
- ☐ Frequent vomiting
- ☐ Other: ________________________________
  ____

Does your child have any of the following conditions?

- ☐ Bites when angry/frustrated
- ☐ Bone/joint/muscle disease
- ☐ Fainting spells
- ☐ Bone/joint/muscle injury
- ☐ Hyperactivity
- ☐ Frequent fevers
- ☐ Trouble sleeping
- ☐ Lack of energy

Is your child seeing a medical specialist for ANY reason? ☐ Yes ☐ No
If yes, specify: ____
Would you like to set up a meeting with the Health Coordinator to discuss your child's health issues?
☐ Yes ☐ No

Dental

Is your child in pain right now because of their teeth? ☐ Yes ☐ No

Nutrition

Is your family currently involved with WIC?	☐ Yes ☐ No
Do you have concerns about your child's eating patterns? (picky eater, over/under eating, other)	☐ Yes ☐ No If yes, specify
Does your child take a vitamin or mineral supplement that contains iron and/or fluoride?	☐ Yes ☐ No If yes, specify
Were the supplements prescribed?	☐ Yes ☐ No
Are there foods not eaten for medical, religious, cultural, or personal reasons?	☐ Yes ☐ No If yes, specify
Is your child on a special diet?	☐ Yes ☐ No If yes, specify
Has your child's appetite changed in the past month?	☐ Yes ☐ No If yes, specify
Does your child have trouble chewing or swallowing?	☐ Yes ☐ No If yes, specify
Do you have any concerns about what your child eats or your child's weight?	☐ Yes ☐ No Please list concerns:________________________________ ____
Does your child have a food allergy documented by a physician?	☐ Yes ☐ No
Does your child need nutritional treatment?	☐ Yes ☐ No List the treatment you feel your child needs ___________ ____
Is your child receiving nutritional treatment?	☐ Yes ☐ No List the treatment your child is receiving ______________ ____

Disability/Mental Health

Is your child currently seeing a counselor or therapist? ☐ Yes ☐ No
If yes, who? ____

Did your child receive services from Early Childhood Intervention (ECI)? ☐ Yes ☐ No
**** speech/language, physical/occupational therapy***
If yes, which agency?____ **IFSP in place?** ☐ Yes ☐ No

______________________________ ______________________
Parent/Guardian Signature **Date**

______________________________ ______________________
Staff Signature **Date**

I verify that I have reviewed this health history form and have taken any needed actions regarding this child.

______________________________ ______________________
Teacher Signature **Date**

ENTERED INTO CHILD PLUS

BY: ______________________________
Date: _____________________________

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