EARLY HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: _____ Date of Birth: _____

Birth

Delivery Method: □Vaginal □C-Section
Birth Weight: _____ Length: _____
Gestation Age: _____weeks □Unknown
Birth Facility: _____

Describe any complications associated with this delivery (Pre-term labor, fetal distress, etc.)

_____

_____

Did the baby have any problems at birth? _____
Describe any observable defects._____
Did the mother have any health problems during this pregnancy (High Blood Pressure, Diabetes, etc.)

_____

_____

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 use diapers or pull ups? □ Diapers □ Pull Ups □ Potty Trained

Preferred Brand: _____
Size:_____

Does your child have any of the following conditions?

- ☐ 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 Where? _____
What does your child drink from?	☐ Regular Cup ☐ Sippy Cup ☐ Bottle
What milk does your child drink?	☐ Breast ☐ Whole Milk ☐ 2% ☐ 1% ☐ Lactose Free ☐ Other: _____
Is your child documented as lactose intolerant per physican?	☐ Yes ☐ No
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
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 If yes, specify
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

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

Does your child have any sleeping problems? □ Yes □ No

What time does your child go to bed? _____ Wake up?_____

Does your child take a nap? □ Yes □ No

Does your child sleep through the night? □ Yes □ No

Does your child have frequent nightmares? □ Yes □ No

Has your child been in daycare or go to a babysitter? □ Yes □ No

Does your child play well with others? □ Yes □ No

Special Concerns

List any additional concerns

_____

_____

_____ _____

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: _____

Revised 11/12/2020