HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: _____ _ Date of Birth: _____

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 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
- ☐ Food:_____

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 Specialist 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 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, who? _____

Special Concerns

List any additional concerns

_____

_____

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Signature **Date**

Revised 2/25/19