Health History (0-12 months)

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Child's Name (Last, First, Middle):	Sex: ☐M ☐F	Birth Date: (MM/DD/YY)	Country of Birth:

Health Information

Name of child's Health Care Provider:_____

Name of child's Dentist: _____

Child's Weight at Birth: Pounds_____ Ounces_____ Length_____ Head Circumference_____
Gestational Age: _____ weeks - Were there concerns at birth? _____

Yes	No	Please answer the following:
☐	☐	Were you told that your child was born early or premature? How early? _____
☐	☐	Were there significant complications during pregnancy?
☐	☐	Were drugs, alcohol or cigarettes part of family life during pregnancy?

Does your child have any of the following?

Yes	No	Health Concerns	If yes, describe
☐	☐	1. Anemia	
☐	☐	2. **Breathing Problems*** **(Asthma, RSV, RAD, other)** **Must answer the questions on the right. Do not leave it blank.**	When was the last time your child had to use medication for the breathing problem? _____ Has your child been hospitalized overnight two or more times in the past year for breathing problems? ☐Yes ☐No Has your child been seen in the emergency room three or more times in the past year for breathing problems? ☐Yes ☐No Comments:
☐	☐	3. Bowel/bladder problems	
☐	☐	4. **Diabetes***	
☐	☐	5. Frequent ear aches or infections	
☐	☐	6. Hearing concerns	
☐	☐	7. **Heart conditions***	
☐	☐	8. Frequent nose bleeds	
☐	☐	9. **Seizures***	
☐	☐	10. Skin condition	
☐	☐	11. Tuberculosis exposure	
☐	☐	12. Vision concerns/wear glasses	
☐	☐	13. Secondhand smoke exposure	
☐	☐	14. Cerebral Palsy	
☐	☐	15. Colic	
☐	☐	16. Reflux	

***Child Health Plan Required/Potentially life-threatening condition**

Health History (0-12 months)

Child's Name:

Yes	No	Health Concerns	If Yes, describe
☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	17. Lead Exposure a. Lived in a house with peeling paint built before 1978? b. Has a sibling/relative or close friend with lead poisoning? c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery) d. Lived near a smelter/battery plant/car repair shop or other lead related industry? e. Have you or your family used home remedies such as azareon, greta, kohl, or pavlooah? (Circle all that apply).	
☐	☐	18. Has your child ever been tested for lead?	
☐	☐	19. Other health concerns? (Please List).	
☐	☐	20. Has your child had any serious illness/injury, surgery or seen a specialist?	
☐	☐	21. Is tobacco currently in use in your home (i.e. smokeless tobacco, cigars, pipe, cigarettes)?	
☐	☐	22. Are drugs or alcohol currently in use in your home?	
☐	☐	23. Has your child been exposed to violence in the home?	
Time (hours)		24. How much time does your child spend being physically active each day?	
Time (hours)		25. How much time does your child spend each day watching TV/videos and playing computer games?	
☐	☐	26. When riding in a car/truck does your child use a car seat/booster seat?	

Non-Food Allergies

27. Does your child have allergies or severe reactions to any of the following? ☐Yes ☐No
If yes, please check only those that apply:

☐**Insect bites/bee stings*** ☐Animals ☐Pollens/Hay Fever ☐Medications ☐Other

(Please specify)

Please describe your child's allergic reaction:

How do you treat your child's allergy?

Has the allergy been diagnosed by a doctor? ☐Yes ☐No

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Child's Name:

Medications

Yes	No	
☐	☐	28. Does your child take any medication? Please list **all** medications:
☐	☐	(28, cont.) Will your child need to take any medication during Early Head Start / Head Start/ECEAP center hours? **[Staff: Please review Medication Administration Procedure, additional action required].**

Dental

Yes	No	Please answer the following:
☐	☐	29. Do you have concerns about your child's teeth or gums? If yes, please describe:
☐	☐	(29, cont.) Do you have a dentist?
☐	☐	(29, cont.) Do you have any family dental concerns?
☐	☐	(29, cont.) Do you clean your child's gums and/or teeth?
☐	☐	(29, cont.) Does your child drink a bottle in bed?
☐	☐	(29, cont.) Is there fluoride in the water at your home? ☐ **Unknown, (staff please check for fluoridation in the child's residential area).**
☐	☐	(29, cont.) Does your child take a prescribed fluoride supplement? (6mo/over)

Nutritional Information

Yes	No	Please answer the following
☐	☐	30. Is your child on WIC?
☐	☐	31. Do you have questions about feeding your child? If yes, please explain:
☐	☐	32. Do you breast feed your child? How often? _____times/24 hours
☐	☐	33. Does your child drink from a baby bottle? How often? _____ times/24 hours
☐	☐	34. Do you feed your child formula? How much per feeding? _____ oz/bottle
☐	☐	35. Does your child drink from a cup?
☐	☐	36. Are you satisfied with what your child eats? How many meals _____ and snacks _____ are offered? If no, please explain:
☐	☐	37. Do you share meals together as a family?
☐	☐	38. Do you have any concerns about your child's growth? Please explain:
☐	☐	39. Do you have any concerns about your child's weight? Please explain:
☐	☐	40. Does your child take a prescribed iron supplement? Why? How often?
☐	☐	41. Does your child currently use any nutritional supplements (Pediasure, Ensure, multivitamins, herbs, etc.)? If yes, what, how often, for what reason?
☐	☐	42. Does your child eat any non-food items? Please list: _____

Child's Name:

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following
☐	☐	43A. Has a medical provider ever told you that your child has a food allergy or intolerance? If yes, please explain.
☐	☐	Is this a life-threatening food allergy? *
☐	☐	43B. Are there foods your child cannot eat for cultural/religious reasons? Is yes, please list:
☐	☐	43C. Are there any other foods your child can not eat? If yes, what foods and why?
☐	☐	Does your child eat the food listed above at home?

If your child has a food allergy or intolerance that has been diagnosed by a doctor, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.

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Developmental History – Sleep

Does your child sleep on his/her ☐ Stomach ☐ Back ☐ Side?

44. How do you put your child to sleep? _____

List Health and Nutrition Education Resources Shared with Parents

☐ Lead Information: _____

☐ Nutritional Information: _____

☐ Fluoride Information: _____

☐ WIC: _____

☐ Safe Sleep Information: _____

☐ Oral Health Care: _____

☐ Other (please list): _____

_____

(i.e., tobacco cessation, helmet, car seat, safety, other information shared).

Child's Name:

Enrollment Review

Parent Signature:	Date:
Family Support Staff Signature(s):	Date Reviewed with Parent:
Teaching Staff Signature(s):	Date Reviewed:
Staff Signature(s):	Date Reviewed:
Interpreter:	Date:
Nurse Consultant:	Date:

2nd Year Review

Parent Signature:	Date:
Family Support Staff Signature(s):	Date Reviewed with Parent:
Teaching Staff Signature(s):	Date Reviewed:
Staff Signature(s):	Date Reviewed:
Interpreter:	Date:
Nurse Consultant:	Date:

If this is child's third year in EHS/HS program, complete a new *Health History Form*.