Health & Nutrition History Form (1-5 Years)

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_____ Grams_____

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 following questions. 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. Walking/climbing difficulties	
☐	☐	13. Vision concerns/wear glasses	
☐	☐	14. Secondhand smoke exposure	

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

Child's Name:

Yes	No	Health Concerns	If Yes, describe
☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	15. Lead Exposure (check all that apply) 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).	
☐	☐	16. Has your child ever been tested for lead?	
☐	☐	17. Other health concerns? (Please List).	
☐	☐	18. Has your child had any serious illness/injury, surgery or seen a specialist?	
☐	☐	19. Is tobacco currently in use in your home (i.e.: smokeless tobacco, cigars, pipe, cigarettes)?	
☐	☐	20. Are drugs or alcohol currently in use in your home?	
☐	☐	21. Has your child been exposed to violence in the home?	
Time (hours)		22. How much time does your child spend being physically active each day? (Running, jumping, dancing, etc.).	
Time (hours)		23. How much time does your child spend each day watching TV/videos and playing computer games?	
☐	☐	24. When riding in a car/truck does your child use a car seat/booster seat?	
☐	☐	25. When your child rides a bike/trike does he/she wear a helmet?	

Non-Food Allergies

26. 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	
☐	☐	27. Does your child take any medication? Please list **all** medications.
☐	☐	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:
☐	☐	28. Has your child complained about pain in the teeth or gums? If yes, please describe.
☐	☐	Is there fluoride in the water at your home? ☐ **Unknown, (staff please check for fluoridation in the child's residential area).**
☐	☐	Does your child take a prescribed fluoride supplement?

Nutritional Information

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

Child's Name:

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following
☐	☐	41A. Are there any foods your child can not eat? If yes, what foods and why? ☐ **Food Allergy*** ☐ Food Intolerance ☐ Cultural/Religious Preference ☐ Child Refuses to Eat ☐ Other: _____ What happens if your child eats the food listed above?
☐	☐	41B. Does your child eat the food listed above at home?
☐	☐	41C. Has a medical provider ever told you that your child has a food allergy or intolerance? If yes, please explain.
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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Child's Name:

List Health and Nutrition Education Resources Shared with Parents

☐ Lead Information: _____

_____

☐ Nutritional Information: _____

_____

☐ Fluoride Information: _____

_____

☐ Other (please list): _____

_____

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

Enrollment Review

Parent Signature:	Date:
Staff Signature(s):	Date Reviewed with Parent;
Staff Signature(s):	Date Reviewed:
Staff Signature(s):	Date Reviewed:
Interpreter:	Date:
Health Coordinator or Nurse Consultant:	Date:

2nd Year Review

Parent Signature:	Date:
Staff Signature(s):	Date Reviewed with Parent:
Staff Signature(s):	Date Reviewed:
Staff Signature(s):	Date Reviewed:
Interpreter:	Date:
Health Coordinator or Nurse Consultant:	Date:

If this is child's 3rd year in EHS/HS/ECEAP program, complete a new *Health & Developmental History Form*.