Health & Developmental History (0-12 Months)

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

Child's Name _____ **Birth date** ____/____/____ ☐ **Male** ☐ **Female**

Health Coverage Date of last Well Child Exam _____ Date of next Well Child Exam _____
Does your child have medical coverage? ☐ Yes ☐ No
Please check type of medical coverage:
☐ Medicaid/DSHS/ (Provider One) ☐ Private Insurance

Birth Information Type of Delivery: ☐ Vaginal ☐ C-Section

Birth Weight: _____lbs. ____oz. Birth Length: _____inches Head Circumference:_____

Gestational Age _____ weeks

Place of birth? ☐ Hospital ☐ Home ☐ Other _____Length of stay

_____

Did the mother have any health concern during this pregnancy/delivery?

_____

_____

___

Did the baby have any concerns at birth?

_____

Were drugs, alcohol, cigarettes a part of family life during pregnancy?_____

Other drugs: _____

Did use stop during pregnancy? _____ If so, when?_____

Child's Health Information

Yes	No	Health Concerns	If yes, please describe:
☐	☐	**Allergy* other than food***	
☐	☐	**Breathing Problems*(Asthma, RSV,RAD, other)**	
☐	☐	Cerebral Palsy	
☐	☐	Colic	
☐	☐	Constipation	
☐	☐	**Diabetes***	
☐	☐	Diarrhea	
☐	☐	Downs Syndrome	
☐	☐	Frequent Earaches/Infections	
☐	☐	Eczema	
☐	☐	Exposure to lead	
☐	☐	Exposure to TB	
☐	☐	Fetal Alcohol	
☐	☐	**Heart Condition***	

Child's Name _____

Child's Health Information – continued			
Yes	**No**	**Health Concerns**	**If yes, please describe:**
☐	☐	Low Birth Weight	
☐	☐	**Seizures***	
☐	☐	Sickle cell	
☐	☐	Yellow Jaundice	
☐	☐	Other	
☐	☐	Surgery	
☐	☐	Drugs or Alcohol used during pregnancy	
☐	☐	Tobacco currently in use in home	
☐	☐	Had your child been exposed to violence in the home?	
☐	☐	When riding in a vehicle does your child use a car seat or booster seat?	
☐	☐	Are drugs and/or alcohol currently in use in your home?	

Medication

Does your child take medication on a regular basis? ☐ Yes ☐ No

If yes, what? _____

Will your child need this medication while in care? ☐ Yes ☐ No

Does your child have medication for emergency use? ☐ Yes ☐ No

If yes, what? _____

Dental Information

Does your child have dental coverage?	☐ Yes	☐ No	
Do you clean your child's gums and/or teeth?	☐ Yes	☐ No	
Do you have any family dental concerns?	☐ Yes	☐ No	
Is there fluoride in your water?	☐ Yes	☐ No	☐ Unknown
Do you have a dentist for your child?	☐ Yes	☐ No	
Does your child take a fluoride supplement? (6 mo/over)	☐ Yes	☐ No	

Feeding/Nutrition

Do you breast feed your child? ☐ Yes ☐ No How often? _____ times/24hrs

Does your child drink from a bottle? ☐ Yes ☐ No How often? _____ times/24hrs

Do you feed your child formula? ☐ Yes ☐ No How much per feeding? ____oz/bottle

If yes, what brand? _____

Child's Name:_____

Feeding/Nutrition -- continued

Has your child been diagnosed with reflux*? ☐ Yes ☐ No
What kind of bottle do you use? _____Nipple type?_____
What do you put in the bottle?_____

Does your baby drink a bottle in bed? ☐ Yes ☐ No
Does your child take a vitamin supplement? ☐ Yes ☐ No
Does your child take a prescribed iron supplement? ☐ Yes ☐ No
Has your child been diagnosed with anemia*? ☐ Yes ☐ No
Do you give your child milk? ☐ Yes ☐ No
If yes, what kind? _____

Which of these foods do you offer your child? (circle)

Eggs Poultry Vegetables Bread Fruit Fish Meat Cereal Rice Juice

Any known food allergies*?

_____
Do you have any questions/concerns about feeding your baby? ☐ Yes ☐ No
If yes, what _____
Do you have any concerns about your child's growth? ☐ Yes ☐ No
If yes, what _____
Is your child on WIC ☐ Yes ☐ No If yes, where? _____

Developmental History

Does your child sleep on his/her? _____ stomach _____back _____side

How do you put your child to sleep? _____

Developmental History (cont.)

Most of Time	Some times	Rarely	Never	
☐	☐	☐	☐	Does your child arch/stiffen when picked up?
☐	☐	☐	☐	Does your child make eye contact when being fed or held?
☐	☐	☐	☐	Do you have concerns about your child's sleep pattern?
☐	☐	☐	☐	Does your child look at objects and follow them with his/her eyes?
☐	☐	☐	☐	Does your child make sounds like ah, eh, uh?
☐	☐	☐	☐	Does your child respond to your voice by looking at you?
☐	☐	☐	☐	Does your child have different cries when she is upset, uncomfortable, happy?
☐	☐	☐	☐	Does your child suck her/his hand or thumb?
☐	☐	☐	☐	Does your baby hold her/his head steady when being held?
☐	☐	☐	☐	Do you need assistance getting a car seat for your baby?
☐	☐	☐	☐	Do you have any concerns about your child's development?

Child's Name:_____

List Health and Nutrition Education Resources Shared with Parents

- ☐ Lead and Your Kids
- ☐ Nutritional Information
- ☐ Fluoride Information
- ☐ Other (Please list)_____

Parent Signature	Date
Staff Signature	Date Reviewed with Parent
Staff Signature	Date Reviewed
Interpreter	Date
Health Coordinator or Nurse Consultant	Date

2nd Year Review	
Parent Signature	Date
Staff Signature	Date Reviewed with Parent
Staff Signature	Date Reviewed
Interpreter	Date
Health Coordinator or Nurse Consultant	Date