Health History and Nutrition Assessment (2 - 5 Years)

Child's Name : ______________________ Date of Birth: ____/___/____ Parent/Guardian name: ______________________
NAME OF CHILD'S HEALTH CARE PROVIDER:______________________
Clinic Name / Location :______________________
Date of last Well Child / Well Baby Exam: ___/____/____ Immunizations: Up to Date Yes No Where given? ______________________
Child's Weight at Birth: _______ Pounds ______ Ounces
Delivery: Normal C Section (circle) Where Delivered? ______________________

Y	N	Health Concerns	Comments
		Aids: Acquired at Birth*	
		Allergy* other than food*	
		Allergy to Food*	See food allergy Section on Back
		Asthma / R.A.D. / Wheezing* ◊	
		Bowel / Bladder Problems	
		Cerebral Palsy	
		Diabetes* ◊ / Hypoglycemia*	
		Downs Syndrome	
		Frequent Earaches/Infections	
		Eczema	
		Exposure to Hepatitis	
		Exposure to Lead / High Lead Level ◊	
		Exposure to Tuberculosis (TB)	
		Failure To Thrive	
		Fetal Alcohol Syndrome	
		Hearing Condition* ◊	
		Heart Condition*	
		Seizures*	
		Sickle Cell Disease*	

Y	N	Health Concerns	Comments
		Surgery	
		Vision Problems / Wears Glasses* ◊	
		Walking / climbing limitations*	
		Drugs or Alcohol used during Pregnancy?	
		Are drugs or alcohol currently in use in your home?	
		Tobacco currently in use in home?	
		Has your child been exposed to violence in the home?	
		When riding in a vehicle does your child use a car seat?	
		When your child rides a bike/trike does he/she wear a helmet?	
Time in Hours	_____	How much time does your child spend being physically active each day? (Running, jumping, dancing, etc.)	
Time in Hours	_____	How much time does your child spend each day watching TV/videos and playing computer games?	
Y	**N**	**MEDICATIONS**	
		Does your child take medication on a regular basis? If yes: Name of medication (s).______________________	
		Will your child need to take any medication during EHS/HS hours?	
		If Yes : Staff: Please review Medication Administration Procedure.* IHCP required	
		Does your child have allergies or severe reactions to any of the following? (circle)	
		Bee Stings* Insect bites Cats Dogs Pollen/Hayfever Medication Other	

(Please explain) :______________________

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* Individual Child Health Plan Required/Potentially life-threatening condition ◊ PIR

Form 1075/ 1080

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Child's Name : ____ Date of Birth: ___/___/___ Parent/Guardian name: ______________________________

Y	N	DENTAL
		Does your child have a regular dentist / dental home? ◊
		Name : of Dentist ______________________
		Clinic Name / Location: ____
		If Yes; Date of last exam: _____/____/____ ◊
		Did your child need fillings? Yes No If yes: how many? ______________
		Has your child complained about pain in the teeth or gums? If yes, describe: ____
		Does your child take a prescribed fluoride supplement?

Y	N	NUTRITIONAL INFORMATION
		Is your child on WIC? If yes; Where? _____________________________________
		Do you have questions about feeding your child? If yes, explain
		Are you satisfied with what your child eats? How many meals ______
		Do you share meals together as a family?
		Does your child drink from a cup?
		Is your child currently breast-feeding?
		Does your child drink from a bottle?
		Are there any foods your child may not eat for cultural, ethnic or religious reasons? If yes, what are they? ________________________________
		Do you have any concerns about your child's growth? Weight? If yes; please explain. ____
		Does your child take a daily vitamin? What kind? ______________________
		Does your child take a prescribed iron supplement for anemia? ◊ How often? ____________
		Does your child currently use any nutritional supplements (Pediasure, Ensure, herbs, etc.)? If yes, what, how often, for what reason? ____
		Do you have any concerns for your child that you would like to share with Head Start?

* Individual Child Health Plan Required/Potentially life-threatening condition ◊ PIR

ALLERGIES: FOOD

Any known Food allergies?* Yes No

Has your child ever had an allergic reaction (hives, swelling, trouble breathing)from eating a particular food?* Yes No

If Yes:

Name of food(s): ____

Type of Reaction: ____

Is you child under a doctor's care for this reaction? Yes No

Doctor's Name: ____

Does your child have an EpiPen Jr. for use if a reaction occurs?* Yes No

If your child has a food or milk allergy 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.

Comments: ____

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1st Program Year 20____/20____

Parent Signature ____Date______________________

Staff Signature____Date______________________

2nd Program Year 20____/20____ Reviewed form with parent. Any changes are indicated and dated.

Parent Signature ____Date______________________

Staff Signature____Date______________________