Health History and Nutrition Assessment (Birth to 2 Years)

Child's Name : ____ Date of Birth: ____/___/____ Parent/Guardian name: ___________________________________
NAME OF CHILD'S HEALTH CARE PROVIDER/MEDICAL HOME ◊:____
Clinic Name / Location :____
Date of last Well Baby Exam: ___/____/____ ◊ Immunizations: Up to Date Y N 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
		Cerebral Palsy*	
		Colic / Constipation /Diarrhea	
		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*	
		Low Birth Weight	
		Seizures*	
		Sickle Cell Disease*	

Y	N	Health Concerns	Comments
		Yellow Jaundice at birth	
		Wheezing / Respiratory Concern / Asthma* ◊	
		Surgery	
		Vision Problems / Wears Glasses* ◊	
		Other (please explain)	
		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?	

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 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) :____

____

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

Form 1075 / 1080

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Y	N	NUTRITION and FEEDING
		Do you breast feed your child? How often? _____ times/24hrs
		Does your child drink from a bottle? How often? _____ times/24hrs
		Do you feed your child formula? ____oz/bottle per feeding
		If yes, what brand? ______________________________
		Has your child been diagnosed with reflux?*
		What kind of bottle do you use? _________________________ Nipple type? ______________
		Do you put other liquids in your child's bottle? Water Juice Other
		Does your baby drink a bottle in bed?
		Does your child take a vitamin supplement? What kind? ____________________________
		Has your child been diagnosed with anemia?* ◊
		Does your child take a prescribed iron supplement?
		Do you give your child milk? If yes, what kind? Whole 2% Skim Flavored
		Baby Food (circle) Jar Stage : ___ Finger foods Table Combination
		Which of the table foods below do you offer your child? (circle)
		Eggs Poultry Vegetables Bread Fruit Fish Meat Cereal Rice Juice
		Do you have any questions/concerns about feeding your baby?
		If Yes; Explain : ____
		____
		Is your Child / Family on WIC? Where? ____
		Do you have any concerns about your child's growth?
		If Yes; Explain : ____
		____

* 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____________________