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you can find it and **EMAIL it** to
enroll@primetimefamily.org when you
complete it.

THANKS!!

Child Health and Nutrition History

STUDENT'S NAME _____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

PARENT/GUARDIAN NAME _____

STAFF NAME _____ **Initials:** _____ **Date:** _____
FIRST LAST

HEALTH OVERVIEW AND SOURCE OF CARE

Child's last PHYSICAL exam Date: _____ Physician/Clinic: _____

Child's last DENTAL exam Date: _____ Dentist/Clinic: _____

Child's INSURANCE: Medicaid State Insurance No Insurance Private

Child's Policy Number (if applicable): _____

Family insurance status: Entire family insured – **Skip to EARLY Child Health Concerns** Entire family uninsured
 Guardian(s) uninsured Please explain: _____

Family insurance eligibility: Entire family eligible Entire family ineligible Guardian(s) ineligible
 Other child(ren) ineligible Please explain: _____

If uninsured, do you and/or the child's siblings access medical and dental care through free or low-cost clinics? Yes No Comment: _____

EARLY CHILD HEALTH CONCERNS

Concerns	Explain any "YES" answers
Did mother have any problems during pregnancy ? <input type="checkbox"/> Yes <input type="checkbox"/> No Child's birth weight: _____lb _____oz	
Has child ever been hospitalized or operated on ? <input type="checkbox"/> Yes <input type="checkbox"/> No Had a serious illness ? <input type="checkbox"/> Yes <input type="checkbox"/> No Had a serious accident or broken bone ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child need help or have trouble with toileting ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child sleep less than 8 hours at night? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child nap? <input type="checkbox"/> Yes <input type="checkbox"/> No	About how many hours per night? Time of day/length of nap?
At what age did your child start walking/talking ?	Age in months when started to walk? Age in months when started to talk?
Was your child born pre-mature (before 37 weeks)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Born at how many weeks? Reason?

CHILD HEALTH CONDITIONS

Concerns	Explain any "YES" answers
Is a <u>physician or dentist</u> currently treating child for any concerns or special conditions ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what conditions?
Does child have, or ever had, any of the following? (check ALL that apply) <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Tendencies <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart/Blood Vessel Disease <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Under/overweight <input type="checkbox"/> High Lead <input type="checkbox"/> Convulsion/seizure – if yes: was it related to a high fever? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other: _____	Explain checked conditions. If checked, date of last convulsion/seizure?
Is child taking medication ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list medication(s):</i> _____ _____	Reason:
VISION QUESTIONS: Do you have any concerns about child's ability to see ? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any concerns about the way child looks at you (or at books, or how he/she watches TV)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has your child ever been referred to, or seen by an eye doctor ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Eye Doctor: Date of last visit: Other Details:
HEARING QUESTIONS: Does child have trouble with ears/hearing ? (e.g., pain in ear, frequent earaches, infections, drainage, hearing loss) <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any concerns about the way child responds when you talk to him/her? Or, how he/she is learning to talk? <input type="checkbox"/> Yes <input type="checkbox"/> No Did child have newborn hearing screening done in the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , what were the results? <input type="checkbox"/> Pass <input type="checkbox"/> Fail Has your child ever been referred to, or seen by an ENT or Audiologist ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Doctor: Date of last visit: Other Details:

Any significant changes should be shared with appropriate staff and documented in Shine Insight.

CHILD DENTAL CONCERNS

CONCERNS	Explain any "YES" answers
Does child have any trouble with teeth, gums, chewing/ eating or mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does child currently receive (check ALL that apply): <input type="checkbox"/> Topical fluoride application <input type="checkbox"/> Fluoridated water <input type="checkbox"/> Fluoride supplement (tablets) <input type="checkbox"/> Fluoride supplement (liquid)	If yes , how long has child been receiving fluoride?

CHILD ALLERGY AND NUTRITION CONCERNS

CONCERNS	Explain any "YES" answers
1. Does child have any allergy problems (e.g., rash, itching, swelling, difficulty breathing)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , is <u>allergy related to</u> (check ALL that apply): Medication Food <input type="checkbox"/> Animals/fur <input type="checkbox"/> Insects/dust <input type="checkbox"/> N/A or None Has allergy ever required emergency medical care? Yes No	If yes, describe reaction. Does child have an EpiPen Jr. or other medication? Describe. Describe reason for emergency care?
FOOD/SPECIAL DIET NEEDS: 2. Does your child have a: <input type="checkbox"/> Yes <input type="checkbox"/> No Food allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Food Intolerance? <input type="checkbox"/> Yes <input type="checkbox"/> No Medical need for a food restriction <input type="checkbox"/> Yes <input type="checkbox"/> No Religious food restriction	Describe: If food/diet related, list food item(s).
3. Does your child currently have problems chewing or swallowing foods or liquids? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe concern:
4. Do you have concerns about your child's size, what he/she eats or feeding behaviors? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , would you like to meet with the Nutritionist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe concern:
Child currently takes/uses (Check ALL that apply): <input type="checkbox"/> Bottle <input type="checkbox"/> Sippy Cup <input type="checkbox"/> Drinking Cup <input type="checkbox"/> Drinking Straw	If yes, how often?

=====STAFF NOTE=====

If any questions from 1 through 3 answered YES in the *Child Allergy and Nutrition Concerns*, refer to Nutritionist.

CHILD ABILITIES AND DEVELOPMENTAL CONCERNS

CONCERNS	Explain any "YES" answers
Does child have a diagnosed disability, with an IEP or IFSP ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe
Do you have any Developmental Concerns in any of the following areas? <input type="checkbox"/> None <input type="checkbox"/> Speech or language <input type="checkbox"/> Physical Development <input type="checkbox"/> Behavior/emotional <input type="checkbox"/> Other:	Describe

CHILD TB RISK ASSESSMENT

RISKS	Explain any "YES" answers
Was your child born in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , in what country was the child born?
Has your child lived or traveled in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , what country? For how long?
In the last 2 years , has your child lived with or spent time with someone who has been sick with TB ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , please explain:
Does your child have any history of immunosuppressive disease or take medications that might cause immunosuppression ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , please explain:

=====STAFF NOTE=====

Any YES answers above in *TB Assessment* section, should be referred to Health team.

FAMILY SMOKING ASSESSMENT

1. Does your **child live with anyone who smokes**? Yes No

2. Does **anyone ever smoke in your home or car**? Yes No

If yes to either question 1 or 2 above, who smokes? _____

3. Do you currently smoke? Yes No, I quit less than a year ago. No, I have never smoked.

IF you answered NO to #3, skip the following 2 questions in this section.

4. If you smoke, **how interested are you in quitting**? Very interested A little interested Not interested

5. Do you want to learn of free ways to help you quit? Yes No I am not sure.

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