PRIME TIME HEAD START

**CENTER:**

# Child Health and Nutrition History

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

**PARENT/GUARDIAN NAME**_____
FIRST LAST

**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

**Insurance Company:** _____ **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**? ☐ Yes ☐ No<br>Child's birth weight:_____lb_____oz | |
| Has child ever been **hospitalized or operated on**? ☐ Yes ☐ No<br>Had a **serious illness**? ☐ Yes ☐ No<br>Had a **serious accident or broken bone**? ☐ Yes ☐ No | |
| Does your child need help or have trouble with **toileting**? ☐ Yes ☐ No | |
| Does your child **sleep** less than 8 hours at night? ☐ Yes ☐ No<br>Does your child nap? ☐ Yes ☐ No | About how many hours per night?<br>Time of day/length of nap? |
| At what age did your child start **walking/talking**? | Age in months when started to walk?<br>Age in months when started to talk? |
| Was your child **born pre-mature** (before 37 weeks)? ☐ Yes ☐ No | Born at how many weeks?<br>Reason? |

# CHILD HEALTH CONDITIONS

| Concerns | Explain any "YES" answers |
|---|---|
| Is a physician or dentist **currently treating** child for **any concerns or special conditions?** ☐ Yes ☐ No | If so, what conditions? |
| **Does child have, or ever had, any of the following? (check ALL that apply)** ☐ No, my child does not have any known health conditions.<br>☐ Asthma ☐ Bleeding Tendencies ☐ Anemia<br>☐ Diabetes ☐ Heart/Blood Vessel Disease ☐ Sickle Cell Disease<br>☐ Liver Disease ☐ Under/overweight ☐ High Lead<br>☐ Convulsion/seizure – if yes: was it related to a high fever? ☐ Yes ☐ No<br>☐ Other: _____ | Explain checked conditions.<br><br>If checked, date of last convulsion/seizure? |
| Is child **taking medication**? ☐ Yes ☐ No<br>*If yes, list medication(s):* _____<br>_____ | Reason: |
| **VISION QUESTIONS:**<br>Do you have any concerns about child's **ability to see**? ☐ Yes ☐ No<br>Do you have any concerns about the way child **looks at you** (or at **books, or how he/she watches TV**)? ☐ Yes ☐ No<br>Has your child ever been **referred to, or seen by an eye doctor**?<br>☐ Yes ☐ No | Name of Eye Doctor:<br>Date of last visit:<br>Other Details: |
| **HEARING QUESTIONS:**<br>Does child have **trouble with ears/hearing**? (e.g., pain in ear, frequent earaches, infections, drainage, hearing loss) ☐ Yes ☐ No<br>Do you have any concerns about **the way child responds when you talk** to him/her? Or, how he/she is learning to talk? ☐ Yes ☐ No<br>Did child have **newborn hearing screening** done in the hospital?<br>☐ Yes ☐ No<br>**If yes**, what were the results? ☐ Pass ☐ Fail<br>Has your child ever been **referred to, or seen by an ENT or Audiologist**?<br>☐ Yes ☐ No | Name of Eye Doctor:<br>Date of last visit:<br>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**? ☐ Yes ☐ No | |
| Does child currently receive any treatments listed below? (check ALL that apply): ☐ No, my child does receive dental/oral treatments.<br>☐ Topical fluoride application ☐ Fluoridated water<br>☐ Fluoride supplement (tablets) ☐ 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)? ☐ Yes ☐ No<br>**If yes**, is allergy related to (check ALL that apply):<br>☐ Medication ☐ Food<br>☐ Animals/fur ☐ Insects/dust ☐ N/A or None<br>**Has allergy ever required emergency medical care?**<br>☐ Yes ☐ No | If yes, describe reaction.<br>Does child have an EpiPen Jr. or other medication? Describe.<br>Describe reason for emergency care? |
| **FOOD/SPECIAL DIET NEEDS:**<br>2. Does your child have a:<br>☐ Yes ☐ No Food allergy?<br>☐ Yes ☐ No Food Intolerance?<br>☐ Yes ☐ No Medical need for a food restriction<br>☐ Yes ☐ No Religious food restriction | Describe:<br>If food/diet related, list food item(s). |
| 3. Does your child currently have **problems chewing or swallowing foods or liquids**? ☐ Yes ☐ No | Describe concern: |
| 4. Do you have concerns about your **child's size, what he/she eats or feeding behaviors**? ☐ Yes ☐ No<br>**If yes**, would you like to meet with the Nutritionist? ☐ Yes ☐ No | Describe concern: |
| Child currently takes/uses (Check ALL that apply):<br>☐ Bottle ☐ Sippy Cup ☐ Drinking Cup ☐ 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**?<br>☐ Yes ☐ No | Describe |
| Do **YOU** have any **Developmental Concerns** in any of the following areas?<br>☐ No ☐ Speech or language ☐ Physical Development<br>☐ Behavior/emotional ☐ 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?<br>☐ Yes ☐ 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?<br>☐ Yes ☐ 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**?<br>☐ Yes ☐ No | **If yes,** please explain: |
| Does your child have **any history of immunosuppressive disease or take medications that might cause immunosuppression**?<br>☐ Yes ☐ 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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