CHILD HEALTH RECORD

CENTER: _____ APPLICATION #:_____

Name of Child: _____ DOB:_____ Gender: ☐ Male ☐ Female

Name of Parent(s)/Guardian(s): _____

Contact Number(s):_____ Email Address:_____

PREGNANCY / BIRTH HISTORY	NO	YES	EXPLAIN "YES" ANSWERS
Did MOTHER have any health problems DURING THIS PREGNANCY OR DURING DELIVERY?	☐	☐	
Did mother visit a Doctor LESS THAN TWO TIMES DURING PREGNANCY?	☐	☐	
Was child born OUTSIDE OF A HOSPITAL?	☐	☐	
Was child born MORE THAN 3 WEEKS EARLY OR LATE?	☐	☐	
What was child's BIRTH WEIGHT?	☐	☐	_____lbs. _____oz.
Did child NEED ADDITIONAL MEDICAL CARE AFTER BIRTH? (Admission to NICU, oxygen, jaundice, etc.)	☐	☐	
Did child or mother STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?	☐	☐	
Is mother PREGNANT now?	☐	☐	If yes, expected due date:_____
HOSPITALIZATIONS AND ILLNESSES	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Has child ever been HOSPITALIZED OR OPERATED ON?	☐	☐	
Has child ever had a SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?	☐	☐	
Has child ever had a SERIOUS ILLNESS?	☐	☐	
HEALTH PROBLEMS	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Does child have FREQUENT: ___SORE THROAT ___COUGH ___STOMACH PAIN, VOMITING, DIARRHEA ___URINARY TRACT INFECTIONS OR TROUBLE URINATING	☐	☐	
Does child have DIFFICULTY SEEING? (Squint, cross eyes, look closely at books)	☐	★ ☐	
Is child WEARING (or supposed to wear) GLASSES?	☐	☐	If yes, LAST VISION EXAM?_____
Does child have problems with EARS/HEARING? (Pain in ear, frequent earaches, discharge, rubbing one ear)	☐	★ ☐	
Have you ever noticed child SCRATCHING HIS/HER anus (butt) WHILE ASLEEP?	☐	☐	If yes, this may be a sign of pinworms
Has child had: ___BOILS ___CHICKENPOX ___ECZEMA ___MEASLES ___GERMAN MEASLES ___MUMPS ___SCARLET FEVER ___WHOOPING COUGH ___HEPATITIS ___TUBERCULOSIS	☐	☐	
Has child had: ___HEART/BLOOD VESSEL DISEASE ___ASTHMA ___DIABETES ___EPILEPSY ___LIVER DISEASE ___RHEUMATIC FEVER ___SICKLE CELL DISEASE ___BLEEDING TENDENCIES	☐	★ ☐	WHAT MEDICINE?_____
Does child have ALLERGY PROBLEMS (Rash, itching, swelling, difficulty breathing, sneezing)?		★	
a. WHEN EATING ANY FOOD? – *Request for Special Meal Accommodation Due to Medical Condition* must be completed by Physician.	☐	☐	WHAT FOODS?_____
b. WHEN TAKING ANY MEDICATION?	☐	☐	WHAT MEDICINE?_____
c. WHEN NEAR ANIMALS, FURS, INSECT, DUST, ETC? (RASH, itching, swelling, difficulty breathing, sneezing)	☐	☐	WHAT THINGS?_____ HOW DOES CHILD REACT?_____
Has child ever had any CONVULSION or SEIZURE?	☐	★ ☐	If yes, WHEN DID IT LAST HAPPEN?_____
Is child TAKING MEDICINE FOR SEIZURES?	☐	☐	WHAT MEDICINE?_____

Is child TAKING ANY MEDICINE NOW? If yes, will it have to be given WHILE CHILD IS AT HEAD START? ***Signed consent & doctor's prescription are required for school nurse to administer any medication.*	____ ____	____ ____	WHAT MEDICINE?_____ HOW OFTEN?_____
Are there ANY CONDITIONS that get in the way of child's EVERDAY ACTIVITIES? Did a DOCTOR OR OTHER HEALTH PROFESSIONAL tell you that child had this problem?	____ ____	____ ____	
Does child need SPECIAL ACCOMMODATIONS WHILE IN SCHOOL? (G-Tube feeding, stroller or walker for mobility, oxygen, etc.)	____	____	
SOCIAL AND EMOTIONAL DEVELOPMENT	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Have there been any BIG CHANGES in your child's life in the LAST SIX MONTHS?	____	____	
Does your child SLEEP LESS THAN 8 HOURS A DAY or HAVE TROUBLE SLEEPING (such as being fretful, having nightmares, wanting to stay up late)?	____	____	
Does your child WORRY A LOT or is your child *VERY* AFRAID OF ANYTHING?	____	____	
Does your child SEEM DEPRESSED or WITHDRAWN?	____	____	
Does your child have any UNUSUAL or UNCONTROLLABLE BEHAVIORS?	____	____	
Do you have any concerns about HOW YOUR CHILD ACTS WITH ADULTS?	____	____	
Do you have any concerns about HOW YOUR CHILD ACTS WITH CHILDREN HIS/HER OWN AGE?	____	____	
Do you have any concerns about HOW YOUR CHILD ACTS AT HOME OR IN THE COMMUNITY?	____	____	
Has your child ever experienced NEGLECT?	____	____	
Has your child ever experienced PHYSICAL OR SEXUAL ABUSE?	____	____	
Has your child ever been exposed to VIOLENT BEHAVIOR or TRAUMA?	____	____	
Do you want your child REFERRRED FOR FURTHER EVALUATION of a SOCIAL-EMOTIONAL concern? ***If YES, complete Universal Referral and ASQ and/or ASQ:SE***	____	____	
CHILD DEVELOPMENTAL CONCERNS	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Does your child have a CERTIFIED DISABILITY?	____	____	
Is your child CURRENTLY RECEIVING SERVICES for a DISABILITY or DEVELOPMENTAL CONCERN?	____	____	___GEIS ___SPED Preschool ___Karinu ___Shriners ___Special Needs Clinic ___GBHWC ___ Other: _____
Do you have any OTHER CONCERNS about your child's development?	____	____	
Do you want your child REFERRRED FOR FURTHER EVALUATION of a SUSPECTED developmental concern? ***If YES, complete Universal Referral and ASQ and/or ASQ:SE***	____	____	

SIGNATURE OF PARENT/GUARDIAN: _____ DATE:_____