CHILD'S HEALTH HISTORY

Policy: The purpose of the health evaluation is to give information about a child's health history, special needs and current health status to allow the center to provide a safe setting and healthful experience for each child.

Child's Name: Date of Birth:

HEALTH & DEVELOPMENT	Yes	No	Explain
Does child have frequent: ☐ ear infections ☐ sore throat ☐ cough ☐ urinary inection/trouble urinating ☐ stomach pain ☐ vomiting ☐ diarrhea			
Does child have difficulty seeing? (Squint, cross eyes, look closely at books?)	☐	☐	
Is child wearing (or supposed to wear) glasses?	☐	☐	Last check up:
Does child have problems with ears/hearing? (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear?)	☐	☐	
Can others understand your child when she/he talks?	☐	☐	
Has child ever had a convulsion or seizure? Is child taking medicine for seizures? No What medicine?	☐	☐	Last Incident?
Is the child taking any other medicine now? (Special consent form must be signed for preschool to administer any medication.) If yes what medicine? _____	☐	☐	Will it need to be given at preschool? No How often?
Has child had: ☐ Boils ☐ Chickenpox ☐ Eczema ☐ German Measles ☐ Measles ☐ Mumps ☐ Scarlet Fever ☐ Whooping Cough			
Has child had: ☐ Asthma ☐ Bleeding Tendencies ☐ Diabetes ☐ Epilepsy ☐ Heart/Blood Vessel Disease ☐ Rheumatic Fever ☐ Sickle Cell Diseases ☐ Low Iron/Anemia			
Is your child in long term medical treatment? No Diagnosis/Medication: Physician:			
Has your child been evaluated for developmental delays, received services from Early On, or the Intermediate School District. Circle all that apply.	☐	☐	
Are there any conditions we have or have not talked about that could disrupt the child's everyday activities? Did a doctor or other health professional tell you the child has this problem? No	☐	☐	
Does your child have any allergies, diagnosed or undiagnosed (rash, swelling, difficulty breathing, sneezing)? No Diagnosed allergies: Reaction: Diagnosed by: Medications:			What Foods? What Things? What Medicine?
Does your child take a nap? If "Yes" describe when and how long.	☐	☐	
Does your child worry a lot , or is he/she very afraid of anything? If "Yes", what things seem to cause him or her to worry or to be afraid?	☐	☐	

12/20 R&H complete and send to DMT; Copy Child's file P:headstart/universal/health/Child's Health History Adobe

R 400.8143(8), HSPPS 1302.42(4) **(OVER)**

 Child's Name:

Health & Development Continued	Tobacco Use / Smoking
How does your child act when playing with a group of other children?	Are all people living in the child's home nonsmokers? No
How does your child tell you he/she has to go to the toilet?	Does anyone living in the child's home use electronic cigarettes or chewing tobacco? No
Can you tell me one or two things your child is interested in or does especially well?	Is the child exposed to second hand smoke? No

To help us keep your child safe in the classroom, does your child wander away, hide, or seek a private place? No
If yes, please explain:

Please share any concerns or challenges you are having with your child that we could support you with.

NUTRITION

What foods does your child especially like?	Does your child often have a problem with any of these? None
Are there any foods your child dislikes?	How does your child feel about meal times? (•) Enjoys ( ) Not interested ( ) Needs encouragement
Please share with us any cultural or ethnic food preferences.	How would you describe your child's appetite? ( ) Good ( ) Average (•) Picky ( ) Poor
How many times a day does your child drink juice? ( ) 1-2 time ( ) 3-4 times (•) 5-6 times ( ) throughout the day	How many time a day does your child eat snacks? ( ) 1-2 times (•) 3-4 times ( ) 5-6 times ( ) throughout the day

	Yes	No	Explain
Does your child take vitamin/mineral supplements? No Do they contain iron? No Do they contain fluoride? No Were they prescribed? No			
Is there any food(s) your child should not eat for medical, religious, or personal reasons? Please indicate those foods.	☐	☐	
Is your child on a special diet? (Diabetic, Vegetarian, allergies etc).	☐	☐	
Do you have concerns about what your child eats or has there been a recent change in appetite?	☐	☐	
Does your child feed him/herself?	☐	☐	
Does your child chew or eat things that are not food?	☐	☐	
Does your child have trouble chewing or swallowing?	☐	☐	

What kind of information/resources do you need to safely prepare your home or outdoor area for children?

Parent /Guardian/Foster Signature: _____ Date: _____