CSNT Community Services of Northeast Texas, Inc.

**Head Start**
*"Building partnerships, changing lives"*

# HEAD START ENROLLMENT HEALTH HISTORY FORM

Child's Name: ____________________________________ Date of Birth: ________________________

Doctor: ___________________________________________ Phone Number:____________________________

Dentist: __________________________________________Phone Number: ___________________________

## Medication

**Is your child currently taking any medication?** ☐ Yes ☐ No
**If yes, what medication and when does the child receive the medication?** _____________________________

_____________________________________________________________________________________________

***if your child receives medication at school, medication administration forms need to be completed by doctor**

## Medical

**Is your child being treated by a physician for any of the following conditions?**

- ☐ Anemia/Sickle Cell
- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures
- ☐ Cardiac Disorders
- ☐ Vision Problems (glasses/difficulty seeing/headaches)
- ☐ Hearing Problems (difficulty hearing/tubes/earaches
- ☐ High Lead Levels

**Please specify**: _____________________________________________________________________________

_____________________________________________________________________________________________

**Does your child have any of the following allergies?**

- ☐ Insect Stings/Bites
- ☐ Medication:__________________________
- ☐ Poison Ivy/Oak
- ☐ Food: ________________________________

**Does your child require an EPI-PEN?** ☐ Yes ☐ No

***If your child has an allergy, an ALLERGY ACTION PLAN will need to be completed by doctor**

**Does your child have any of the following problems?**

- ☐ Seasonal Allergies: _____________________
- ☐ Eczema, hives, other skin problems
- ☐ Bed wetting
- ☐ Daytime wetting
- ☐ Frequent diarrhea
- ☐ Frequent urination
- ☐ Frequent constipation
- ☐ Painful urination
- ☐ Wears diapers/training pants
- ☐ Frequent indigestion
- ☐ Frequent stomachaches
- ☐ Frequent vomiting
- ☐ Other: _______________________________ ___________________________________

**Does your child have any of the following conditions?**

- ☐ Bites when angry/frustrated
- ☐ Bone/joint/muscle disease
- ☐ Fainting spells
- ☐ Bone/joint/muscle injury
- ☐ Hyperactivity
- ☐ Frequent fevers
- ☐ Trouble sleeping
- ☐ Lack of energy

**Do immediate/extended family members or friends smoke in the home and/or car while the child is present?** ☐ Yes ☐ No
**Is your child seeing a medical specialist for ANY reason?** ☐ Yes ☐ No
If yes, specify: _______________________________________________________________________________

**(Two Page Document)**

**Would you like to set up a meeting with the Health Specialist to discuss your child's health issues?**
☐ Yes ☐ No

## Dental

**Is your child in pain right now because of their teeth?** ☐ Yes ☐ No
If yes, is your child seeing a dentist and if so list the dentist name and phone number? ☐ Yes ☐ No
______________________________________________________________________________

## Nutrition

| Question | Response |
|---|---|
| Is your family currently involved with WIC? | ☐ Yes ☐ No |
| Do you have concerns about your child's eating patterns? (picky eater, over/under eating, other) | ☐ Yes ☐ No<br>If yes, specify: |
| Does your child take a vitamin or mineral supplement that contains iron and/or fluoride? | ☐ Yes ☐ No<br>If yes, specify: |
| Were the supplements prescribed? | ☐ Yes ☐ No |
| Are there foods not eaten for medical, religious, cultural, or personal reasons? | ☐ Yes ☐ No<br>If yes, specify: |
| Is your child on a special diet? | ☐ Yes ☐ No<br>If yes, specify: |
| Has your child's appetite changed in the past month? | ☐ Yes ☐ No<br>If yes, specify: |
| Does your child have trouble chewing or swallowing? | ☐ Yes ☐ No<br>If yes, specify: |
| Do you have any concerns about what your child eats or your child's weight? | ☐ Yes ☐ No<br>Please list concerns:________________________________<br>__________________________________________ |
| Does your child need nutritional treatment? | ☐ Yes ☐ No<br>List the treatment you feel your child needs: ___________<br>__________________________________________ |
| Is your child receiving nutritional treatment? | ☐ Yes ☐ No<br>List the treatment your child is receiving:_____________<br>__________________________________________ |

## Mental Health

**Is your child currently seeing a counselor or therapist?** ☐ Yes ☐ No
If yes, who? ____________________________________________________________

**Is your child currently receiving services from Early Childhood Intervention (ECI)?** ☐ Yes ☐ No
**** speech/language, physical/occupational therapy***
If yes, who? ____________________________________________________________

## Special Concerns

List any additional concerns:
______________________________________________________________________________
______________________________________________________________________________

________________________________________ ____________________________
**Parent/Guardian Signature** **Date**

________________________________________ ____________________________
**Staff Signature** **Date**

**Revised 11/1/18**