Head Start

"Building partnerships, changing lives"

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CHILD HEALTH INFORMATION-1

Child's Name: _____

GENERAL HEALTH HISTORY

****Medical and Dental Coverage information-see Eligible Child Health Form**

MEDICATION

Is your child currently taking any medication? ☒Yes ☐No If "Yes", what type_____

Will this medication need to be given during school class time? ☒Yes ☐No

MEDICAL

Please check any of the following health condition/s to which your child has a Physician diagnosis:

☐ Anemia or Sickle Cell Anemia ☐ Asthma ☐ Diabetes ☐ Seizure Disorders ☐ Cardiac Disorders

Please specify:

Please list any other health issues your child may have or you are concerned your child may have:

Allergies To: ☐ Bee Stings ☐ Food ☐ Poison Ivy/Oak ☐ Insect Bites ☐ Medication

Specify Food Allergy: _____ Specify Medication Allergy:_____

Does your child's allergy require an EPI Pen? ☑Yes ☐No

Sinus/Skin Problems:

☐ Seasonal Allergies Please Specify: _____ ☐ Eczema, hives, other skin problems

Bowel/Urinary Tract Problems:

☐ Bed Wetting ☐ Frequent diarrhea ☐ Frequent urination ☐ Wears diapers/pull-ups

☐ Daytime wetting ☐ Frequent constipation ☐ Painful urination

Vision Problems:

☐ Born more than 6 weeks premature ☐ Difficulty seeing ☐ Headaches ☐ Wears Glasses

Hearing Problems:

☐ Difficulty hearing ☐ Frequent earaches ☐ Tubes in ears

Digestion Problems:

☐ Frequent Indigestion ☐ Frequent Stomachaches ☐ Frequent Vomiting

Other Conditions:

☐ Bites when angry/frustrated ☐ Fainting Spells ☐ Hyperactivity ☐ Trouble Sleeping
☐ Bone/Joint/muscle disease ☐ Bone/Joint/muscle injury ☐ Frequent Fevers ☐ Lack Of Energy

Do immediate/extended family members or friends smoke in the home and/or car while children are present? ☒Yes ☐No

Is your child seeing a medical specialist for any reason? ☐Yes ☒No

If "Yes", who?

☐Yes ☑No I would like to set up a meeting with the nurse to discuss my child's health issues.

CHILD HEALTH INFORMATION-2 **Child's Name: _____**

DENTAL

Is your child in pain right now because of their teeth? ☑Yes ☐No…if "Yes", is your child seeing a dentist? ☐Yes ☐No

If "Yes" give your child's dentist name and phone number: _____

NUTRITION

Is your family currently involved with WIC? ☐Yes ☐No

Do you have concerns about your child's eating patterns? ☐Yes ☐No if "Yes", specify:_____
(e.g. picky eating, under-eating, over-eating, other)

Does your child take a vitamin or mineral supplement which
contains iron and/or fluoride? ☐Yes ☐No if "Yes", specify:_____

Were the supplements prescribed? ☐Yes ☐No

Are there foods not eaten for medical, religious, culture or personal reasons? ☐Yes ☐No if "Yes", specify: _____

Is your child on a special diet? ☐Yes ☐No

Has your child's appetite changed in the past month? ☐Yes ☐No

Does your child have trouble chewing or swallowing? ☐Yes ☐No if "Yes", specify: _____

Do you have concerns about what your child eats or your child's weight? ☐Yes ☐No if "Yes", please list concerns below

Please list concerns: _____

_____

Does your child need nutritional treatment? ☐Yes ☐No If "Yes", list below the treatment you feel your child needs:

_____

Is your child receiving nutritional treatment? ☐Yes ☐No If "Yes", list the treatment your child is receiving:

_____

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
(e.g. speech/language, physical/occupational therapy)
Is "Yes", who? _____

SPECIAL CONCERNS (list below): _____

_____

_____

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Staff Signature **Date**

revised 11/5/18