HEALTH AND DEVELOPMENTAL HISTORY
1 – 5 YEAR OLDS

Child's Name (Last, First, Middle)	Sex ☐ M ☐ F	Birth Date (mm/dd/yy)	Country of Birth

HEALTH INFORMATION

NAME OF CHILD'S HEALTH CARE PROVIDER: _____

		Child's Weight at Birth Pounds_____ Ounces_____ Grams_____
YES	**NO**	Please answer the following:
☐	☐	Were you told that your child was born early or premature? How early? _____
☐	☐	Were there significant complications during pregnancy?
☐	☐	Were drugs, alcohol or cigarettes part of family life during pregnancy?

Does your child have any of the following?

YES	NO	Health Concerns	If Yes, describe
☐	☐	1. Anemia	
☐	☐	**2. Respiratory concerns***	
☐	☐	3. Bowel/bladder problems	
☐	☐	4. **Diabetes***	
☐	☐	5. Frequent ear aches or infections	
☐	☐	6. Hearing concerns	
☐	☐	**7. Heart conditions***	
☐	☐	8. Frequent nose bleeds	
☐	☐	9. **Seizures***	
☐	☐	10. Skin condition	
☐	☐	11. Tuberculosis exposure	
☐	☐	12. Walking/climbing difficulties	
☐	☐	13. Vision concerns/wear glasses	
☐	☐	14. Secondhand smoke exposure	
		15. Lead Exposure (check all that apply)	
☐	☐	a. Lived in a house with peeling paint built before 1978?	
☐	☐	b. Has a sibling/relative or close friend with lead poisoning?	
☐	☐	c. Lives with an adult whose job or hobby involves lead? (ie welding, stained glass or pottery)	
☐	☐	d. Lived near a smelter/battery plant/car repair shop or other lead related industry?	
☐	☐	e. Have you or your family used home remedies such as azareon, greta, kohl, or pavlooah (circle all that apply)	
☐	☐	16. Has your child ever been tested for lead?	
☐	☐	17. Other health concerns? (Please List)	
☐	☐	18. Has your child had any serious illness/injury, surgery or seen a specialist?	
☐	☐	19. Is tobacco currently in use in your home? (i.e.: smokeless tobacco, cigars, pipe, cigarettes)	

*** Child Health Plan Required/ Potentially life-threatening condition**

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Yes	No	
☐	☐	20. Are drugs or alcohol currently in use in your home?
☐	☐	21. Has your child been exposed to violence in the home?
Time (hours)		22. How much time does your child spend being physically active each day? (running, jumping, dancing, etc.)
Time (hours)		23. How much time does your child spend each day watching TV/videos and playing computer games?
☐	☐	24. When riding in a car/truck does your child use a car seat/booster seat?
☐	☐	25. When your child rides a bike/trike does he/she wear a helmet?

MEDICATIONS

YES	NO	
☐	☐	Does your child take any medication? Please list **all** medications.
☐	☐	Will your child need to take any medication during Early Head Start / Head Start/ECEAP center hours? [Staff: Please review Medication Administration Procedure, additional action required]

ALLERGIES

Does your child have allergies or severe reactions to any of the following? ☐ Yes ☐ No
If yes, please check only those that apply
☐ Insect bites/bee stings* ☐ Animals ☐ Pollens/Hay Fever ☐ Medications ☐ Food* ☐ Other
(Please specify)

Please describe your child's allergic reaction

How do you treat your child's allergy?

Has the allergy been diagnosed by a doctor? ☐ Yes ☐ No

If your child has a food or milk allergy that has been diagnosed by a doctor, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.

DENTAL

NAME OF CHILD'S DENTIST: _____

YES	NO	Please answer the following:
☐	☐	Has your child complained about pain in the teeth or gums? If yes, please describe
☐	☐	Is there fluoride in the water at your home? ☐ **Unknown, (staff please check for fluoridation in the child's residential area)**
☐	☐	Does your child take a prescribed fluoride supplement?

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BEHAVIORAL INFORMATION

Most of the time	Some times	Rarely	Never	
☐	☐	☐	☐	1. Does your child indicate/ask for help from children/adults when necessary?
☐	☐	☐	☐	2. Can your child stay with activities he/she enjoys for at least 10 minutes (not including watching television)? (children 3 – 5 years only)
☐	☐	☐	☐	3. Does your child have an opportunity to play with other children his/her age?
☐	☐	☐	☐	4. Does your child show concern for other people's feelings? For example, does he/she look sad when someone is hurt? (children 3 – 5 years only)
☐	☐	☐	☐	5. Do you have concerns about your child's eating, sleeping, or toileting habits?
☐	☐	☐	☐	6. Does your child cry, scream or stomp his/her feet for long periods of time?
☐	☐	☐	☐	7. Does your child seem more active than other children his/her age?
☐	☐	☐	☐	8. Does your child have an unusual amount of fears or anxieties?
☐	☐	☐	☐	9. Does your child try to hurt himself/herself, other children, adults or animals (for example, by kicking or biting)?
☐	☐	☐	☐	10. Does your child arch/stiffen when picked up?
☐	☐	☐	☐	11. Can your child move easily from one activity to another, such as from playtime to mealtime?
☐	☐	☐	☐	12. Can your child settle himself/herself down after periods of exciting activity?
☐	☐	☐	☐	13. Does your child stay away from dangerous things, such as fire and moving cars? (children 3 -5 years only)
☐	☐	☐	☐	14. Does your child make eye contact when feeding/holding/communicating?

NUTRITIONAL INFORMATION

YES	NO	Please answer the following
☐	☐	Is your child on WIC?
☐	☐	Do you have questions about feeding your child? If yes, please explain
☐	☐	Are you satisfied with what your child eats? How many meals _____ and snacks _____ are offered? If no, please explain.
☐	☐	Do you share meals together as a family?
☐	☐	Does your child drink from a cup?
☐	☐	Is your child currently breast feeding?
☐	☐	Does your child drink from a bottle?
☐	☐	Are there any foods your child may not eat for cultural, ethnic or religious reasons? If yes, what are they?
☐	☐	Do you have any concerns about your child's growth? Please explain.
☐	☐	Do you have any concerns about your child's weight? Please explain.
☐	☐	Does your child take a vitamin? Why? How often?
☐	☐	Does your child take a prescribed iron supplement? Why? How often?
☐	☐	Does your child currently use any nutritional supplements (pediasure, ensure, herbs, etc.)? If yes, what, how often, for what reason?
☐	☐	Does your child eat non-food item? Please list _____

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LIST HEALTH AND NUTRITION EDUCATION RESOURCES SHARED WITH PARENTS

☐ Lead Information _____

☐ Nutritional Information _____

☐ Fluoride Information _____

☐ Other (Please list) _____

(i.e. tobacco cessation, helmet, car seat, safety, other information shared)

Enrollment Review

Parent Signature	Date
Staff Signature(s)	Date Reviewed with Parent
Staff Signature(s)	Date Reviewed
Staff Signature(s)	Date Reviewed
Interpreter	Date
Health Coordinator or Nurse Consultant	Date

2nd Year Review

Parent Signature	Date
Staff Signature(s)	Date Reviewed with Parent
Staff Signature(s)	Date Reviewed
Staff Signature(s)	Date Reviewed
Interpreter	Date
Health Coordinator or Nurse Consultant	Date