



CHILD HEALTH and NUTRITION HISTORY

Child's name: _____ Date of birth: _____

Family Service Specialist: _____ Center: _____

Parent/guardian name: _____ Phone: _____

Does your child have medical and dental insurance? Yes No

Type of insurance: _____

Has your child been seen by a primary health care provider? Yes No

Primary health care provider or clinic name: _____ Date of last well child exam: _____

Has your child had an anemia test (hemoglobin or hematocrit)? Yes No.....**AND **Blood lead level test?** Yes No

Has your child been seen by a dentist? Yes No

Dentist or clinic name: _____ Date of last dental exam? _____

Does your child take fluoride supplements and/or use fluoride tooth paste? Yes No

Does your family drink fluoridated water? Yes No

Does your child currently receive WIC services? Yes No

Does your child take a bottle or sippy cup to bed at night? Yes No

What type of liquid is in the bottle/cup? _____

Is your child: Wearing diapers Wearing pull-ups In the process of toilet training Using toilet regularly

Comments: _____

Does anyone in the child's home use tobacco? Yes No

If yes, describe type of tobacco and location of use: _____

Does your child take medications? Yes No

If yes, please list current medications: _____

PREGNANCY AND BIRTH HISTORY	
Prenatal: When did mother first receive prenatal care: <input type="checkbox"/> 1 st trimester <input type="checkbox"/> 2 nd trimester <input type="checkbox"/> 3 rd trimester <input type="checkbox"/> No prenatal care	
Gestational age at birth? _____ Weeks	Birth weight: _____ lbs _____ oz length: _____ in
Were there any complications with the pregnancy or delivery of this child including low birth weight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain: _____	
Were there any concerns with the baby at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain: _____	
Length of infant's hospital stay? _____ days	Comments: _____



Child's name: _____ Date of birth: _____

Current or past history of your child (check ALL that apply)?

MEDICAL		NUTRITION
<input type="checkbox"/> Allergies (pollen, bees, cats, etc.): <hr/> <input type="checkbox"/> Allergies (medication): <hr/> <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Anemia <input type="checkbox"/> Sickle cell disease or trait <input type="checkbox"/> Eczema / skin conditions <input type="checkbox"/> Frequent ear infection <input type="checkbox"/> Frequent nose bleed	<input type="checkbox"/> Frequent sore throat / strep infections <input type="checkbox"/> Frequent urinary infections <input type="checkbox"/> History of head injury <input type="checkbox"/> Heart concerns <input type="checkbox"/> Liver disorder <input type="checkbox"/> High lead level <input type="checkbox"/> Kidney disorder <input type="checkbox"/> Pneumonia <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Surgeries: <hr/>	<input type="checkbox"/> Frequent Constipation <input type="checkbox"/> Frequent Diarrhea <input type="checkbox"/> Frequent vomiting <input type="checkbox"/> Frequent stomach ache <input type="checkbox"/> Feeding tube <input type="checkbox"/> Food allergy: <hr/> <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Concern with weight by you or child's doctor <input type="checkbox"/> Pain/difficulty chewing or swallowing <input type="checkbox"/> Special diet (cultural, religious): <hr/> <input type="checkbox"/> Special diet (medical): <hr/>
DEVELOPMENTAL/SOCIAL-EMOTIONAL	HEARING/VISION	
<input type="checkbox"/> Receiving current counseling services <input type="checkbox"/> Learning or behavior concern <input type="checkbox"/> Loss of parent <input type="checkbox"/> Frequent mood change <input type="checkbox"/> Speech delay or concern <input type="checkbox"/> Physical development concern <input type="checkbox"/> Sleep habits: Naps _____ hr/day Night _____ hr/night _____ Frequent nightmares _____ Frequent bedwetting	<input type="checkbox"/> Hearing difficulty <input type="checkbox"/> Speech difficulty <input type="checkbox"/> Tube in ear(s) <input type="checkbox"/> Vision / eye problem <input type="checkbox"/> Wears glasses	
ANY OTHER COMMENTS/CONCERNS		

Yes No Is your child currently being treated for any of the above? If yes, which one(s)? _____

Yes No Does your child require special medical procedures during the time he/she would be under the care of CCSD HS/EHS staff? If yes, please describe: _____

Medical conditions – For asthma, seizures, allergies (requiring Epi-pen), and medical accommodations or procedures: please provide doctors order, medications, or procedure supplies from pharmacy.

Developmental and/or social-emotional concerns – If concern requires accommodations in the classroom, please notify FSS or Center Coordinator. If child is receiving current therapy services please provide FSS with documentation or current IEP or current IFSP.

Medical diet, food allergy/sensitivity – Notify FSS or Center Coordinator. Provide Doctors Order completed by physician for medical issue/disability which may alter the child's diet from the regular choices offered to all HS/EHS children.

Milk replacement (lactose free, soy milk, etc) – Provide a Doctors Order and notify Center Coordinator or FSS.

Parent request (religious or cultural) – Notify FSS of your request. Requests are accommodated to the extent possible for specific need.



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To be completed by HS/EHS Staff after review of health and nutrition history:

Follow-up needed? Yes No (If yes, complete section below)

CONCERN	ACTION PLAN List specific steps to be completed; list review year dates and comments)

 Parent / guardian signature Date

 Reviewed by – staff signature and title (FSS / Nurse) Date

 Reviewed by – Center Coordinator / Lead Teacher/Childcare Provider Date

Year Two or Site / Program Transfer	
Returning / continuing student: Review Health and Nutrition History with parent / guardian and document updates in Follow-up section with date.	
_____ Parent / guardian signature	_____ Date
_____ Staff signature	_____ Date

Year Three or Site / Program Transfer	
Returning / continuing student: Review Health and Nutrition History with parent / guardian and document updates in Follow-up section with date.	
_____ Parent / guardian signature	_____ Date
_____ Staff signature	_____ Date