Charleston County SCHOOL DISTRICT excellence is our standard

Early Head Start

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: ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ 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? ☐ Yes ☐ No

If yes, explain: _____

Were there any concerns with the baby at birth? ☐ Yes ☐ No

If yes, explain: _____

Length of infant's hospital stay? _____ days Comments: _____

3180 Thomasina McPherson Blvd, North Charleston, SC 29451
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Child's name: _____ Date of birth: _____

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

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

☐ 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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Child's name: _____ Date of birth: _____

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

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