Head Start Child Health History

Child's Health History	YES	NO	If yes, please explain.
Has the child ever been hospitalized or had a major operation?			
Has the child had a serious accident or illness? If so, explain: _____			(Circle "Yes" or "No"): Was child hospitalized/ER visit? Y/N Was the situation resolved? Y/N
Does child have any allergies:			
•When eating any foods?			What foods?
•When near animals, furs, insects, dust, etc.?			What types?
•When taking any medication?			What medication?
Describe past allergic reactions:			
Does child require medication?			Does medication need to be given at school? YES____ NO _____
Is child being treated by a physician for any condition (asthma, seizures, anemia, diabetes, heart condition, etc...)?			If yes, for what condition? _____ Does the child require medication? Y/N_____ Will this medication be needed during school hours? Y/N_____
Vision History	YES	NO	
Does your child experience any of the following:			
•Squinting			
•Crossed eyes			
•Difficulty seeing far away			
•Difficulty seeing up-close			
•Child has prescription glasses			
Does your child:			
•Have problems hearing?			
•Have frequent ear infections (more than 3 in 1 year)?			
•Have tubes in ears?			
Dental History	YES	NO	Please explain if needed
Has your child seen a dentist?			
•Brushes teeth regularly			
•Sucks thumb?			
•Chews inappropriate items or has problems chewing?			
•Complains about dental problems/teeth hurting?			
•Uses a bottle?			
•Has swallowing problems?			
Social Emotional Development/ Behavior	YES	NO	Please explain if needed
•Does your child have a temper or outburst?			
•Does child refuse to comply with adults requests?			
•Does child have difficultly paying attention to tasks?			
•Is child timid or easily frightened?			
•Is child distracted by extra stimuli?			
•Can child be aggressive?			
•Child cries easily?			
Nutrition Assessment	YES	NO	Please explain if needed
What foods does child especially like?			
What foods does child dislike?			
Does child take vitamins regularly?			
Can child feed self?			
Does child have a good appetite?			
Family History	YES	NO	
Is there a family history of vision problems?			
Is there a family history of hearing problems?			
Is there anything else you would like us to know about your child?			

Parent Signature _____ **Date** _____

Updated 9/26/17 VL