Stillwater
AREA PUBLIC SCHOOLS

CHILD HEALTH AND DEVELOPMENT HISTORY (3-6 YEARS)

Child's Name:______________________________ __M __F Birthdate: __________ Age __________
(For office use only)
MARSS other ID: _________ Languages spoken at home:_____________________________________

Parent/Guardian Name(s): ____

Person completing form: _______________________________________ Date: ____________________

How often does your child see a doctor or nurse? _____________ Date of last well child visit: __________

How often does your child see a dentist? ______________ Date of last dental check-up: ______________

Date of your child's most recent comprehensive vision (eye) exam, if your child received one:__________
The comprehensive vision exam is performed by an optometrist or ophthalmologist.
Does your child have health insurance? Yes No Applied

Please check the boxes if you or your child use, if any:

Early Childhood Family Education	Child & Teen Check-ups	Child care center
Early Childhood Special Education	School-based pre-K	Family/neighbor care
Follow Along program	Private preschool	Library
Parenting Education	Head Start	WIC
Parks and Recreation programs	Foster Care	Food shelf

HEALTH

Please check any concerns that apply to your child and describe:

Allergies: food medicine animals/insect dust/mold seasonal _______________

Takes medicines, herbs and/or vitamins: ____

Visits to health specialist(s), hospital stays and/or surgeries: _______________________________

Serious injuries or illnesses, visit to Emergency Room. Reason and date: ____________________

Head injuries (loss of consciousness?)____

Lead poisoning, level if known: ____

Trouble breathing, coughing or asthma:____

Skin problems or rashes:____

Seizures, staring spells:____

Vision problem or wears glasses: ____

Ear (PE) tubes or hearing problems: ____

Teeth: one or more cavities: ____

Eating, stomach concerns or constipation: ____

Mental health concerns such as anxiety, depression or attention concerns? ________________

Adopted, if Yes, at what age: ____

Problems during pregnancy or birth?_______________________

Born more than three weeks early or late ____# weeks at birth.   Child's birth weight: __________

At birth, stayed in the hospital longer than mother, reason: ______________________________

Is it possible that before you knew you were pregnant you took medications, alcohol, cigarettes, or street drugs? ____

______Please list any other concerns: ____

____

Please check any Family Health problems (child's parents or siblings):

Attention problems	Vision problems	Diabetes
Allergy	Learning Problems	Growth Problems
Asthma	Mental Health Disorders	Epilepsy/Seizures
Deafness/Hearing	Sickle Cell Anemia/Trait	Other health problems

CHILD'S DAILY ROUTINES

______Sleeps at___ pm. Wakes up at____am.	Gets 60 minutes or more of exercise each day
Has difficulty falling/staying asleep	Is NOT able to/does NOT get 60 minutes of exercise
Takes a nap: from ____to____	______TV/Video Game/Screen Time: hours per day

Every day eats some foods from the food groups:

5-9 servings fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

3 servings calcium rich foods: milk, cheese, yogurt, soymilk, tofu

2-3 serving iron rich foods: fish, poultry, meat, beans, legumes, eggs

3 or more servings: whole grains: whole wheat bread, cereal, brown rice, tortillas, crackers, pasta

More than one serving of sweets, fruit drinks or junk food each day

In the past 12 months, we worried whether our food would run out before we could buy more __yes __ no

In the past 12 months, the food we bought didn't last and we didn't have money to get more __yes __no

HOME SAFETY

Current housing situation:

Renting or homeowner   Doubled up with friends or family   Hotel or motel

Emergency shelter/transitional housing   Unsheltered (cars,parks,and campgrounds, temporary)

Does your child live or play in a home or building built before: ___1978 ___remodeled in last 5 years?

Does anyone at home or who cares for your child: ___use tobacco/smoke ___ use alcohol ___have a gun(use safety lock)

Do you have concerns that your child is exposed to: violence   street drugs   unsafe conditions

Do you and /or your child use/have the following:

car seats   bike helmets   smoke detector   carbon monoxide detector

LEARNING

My child learned to do things at the same age as other children (sit, stand, walk, toilet trained, etc.)

If not, please explain:____

My child needs help with: toileting   activity/mobility   dressing   nutrition/eating (Help to eat Oranges? Milk?

Other:____

Please check any of the following:

Says numbers 1 to 10   understands other people

Has trouble speaking or hard to understand   Able to follow directions

Has trouble being understood by others   Plays in a variety of ways

Seems clumsy when using hands   Walks or runs poorly (falls)