A Community Action Agency

EARLY HEAD START
HEALTH & DEVELOPMENTAL HISTORY

To Be Completed/Reviewed/Updated by Head Start Parent/Guardian Each Year

CHILD'S NAME: ____ **DATE:** __________________

1. Does your child have a doctor for regular well visits, sick visits and immunizations? Yes____ No____
   Doctor's name & phone #: ____

2. Does your child see a dentist for routine dental care? Yes ____ No ____
   Dentist's name & phone #: ____

3. Is your child covered by health insurance? Yes ____ No ____
   Is your child covered by dental insurance? Yes ____ No ____

4. If yes, what insurance?
   Medicaid _____ MI Child _____ Private Health Insurance _____ Private Dental Insurance _____
   Insurance #: ______________________________________

5. Has your child ever been hospitalized or operated on? Yes____ No____
   If yes, please explain: ____

6. Has your child ever had a serious injury or accident? Yes____ No______
   If yes, please explain: ____

7. Please check if your child has any of the following health problems:

ALLERGY to:	o DIABETES	o OVERWEIGHT
o Peanuts	o ECZEMA/SKIN PROBLEMS	o SEIZURES/EPILEPSY
o Foods: ___________________	o HEARING (circle below)	o SICKLE CELL DISEASE
o Dust/Grass/Pollen	Frequent Earaches/Infections	o VISION (circle below)
o Insect Bites/Bee Stings	Ear Tubes – Now/In Past	Squints
o Latex	Trouble Hearing/Turns Sound Up	Holds Object Close
o Animals/Fur	Favors One Ear	Sits Close to TV
o Medicine: ________________	o HEART CIRCULATION	Eyes Appear Crossed
	o HIGH LEAD LEVELS	Wears Glasses
o ASTHMA	o LACTOSE INTOLERANCE	
o BLEEDING PROBLEMS	o LIVER DISEASE	o OTHER HEALTH PROBLEMS:
o CANCER	o LOW IRON/ANEMIA	___________________________

8. Does your child need to take medication at Early Head Start/Head Start? Yes _____ No _____
   If yes, please explain: ____
   (Special consent forms will need to be signed by you and your child's doctor.)

9. Has your child had chickenpox? Yes____ No _____ If yes, what year? _____________

10. Do you have any concerns about your child's health? Yes ____ No ____
    If yes, please explain: ____

11. Would you like to speak to the health staff about any health questions or concerns? Yes ____ No ____
    If yes, please explain: ____

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EARLY HEAD START

HEALTH & DEVELOPMENTAL HISTORY (continued)

12. Did your child have problems at birth, such as premature birth, breathing problems? Yes____ No____
    If yes, please explain____
    What was your child's birth weight? _________________________

13. Is your child toilet trained? Yes____ No____

14. Do you feel that your child developed later than normal in any of the following activities? Please circle.

    - Sitting up without help
    - Feeding self
    - Crawling
    - Dressing self
    - Walking
    - Learning to use the toilet
    - Talking

    If you circled any activities above, please explain:
    ____

15. Does your child ever have trouble walking, climbing, reaching for or holding onto objects?
    Yes____ No____ If yes, please explain: ____

16. Do you have any concerns about your child's attention span? (Examples would be your child has difficulty sitting still or focusing on an activity for longer than a few minutes.)
    Yes____No____ If yes, please explain:____

17. Do you have any concerns about your child's speech such as the following?

    - Your child has difficulty saying what he/she wants.
    - You have difficulty understanding what your child is saying.
    - People outside of the family have difficulty understanding what your child is saying.

18. Have there been any big changes in your child's life during the last six months?
    Yes____ No____ If yes, please explain: ____
    ____

19. Are you or your family having any problems that might affect your child?
    Yes____ No____ If yes, please explain: ____
    ____

20. Is there anything else you would like us to know about your child?
    Yes____ No____ If yes, please explain: ____
    ____

1st Yr Parent Signature: ____ Date: _______________
2nd Yr Parent Signature: ____ Date: _______________
3rd Yr Parent Signature: ____ Date: _______________

Reviewed by Staff 1st Yr: ____ Date: _______________
Reviewed by Staff 2nd Yr:____ Date:_______________
Reviewed by Staff 3rd Yr:____Date:_______________