# Skagit/Island Head Start
## HEALTH INFORMATION FORM CONTINUED

| Childs Name | Sex: F ❑ M ❑ | Birthdate: |
|---|---|---|

Childs Health Care Provider: _____

Child's Dental Home or Dentist: _____

Date of last Well Child: ___ / _____ Date of last Dental Exam: ___ / _____
Month Year Month Year

**Health Insurance Medical & Dental:**
*(check one* PIR*)*

❑ Apple Health ❑ CHPW
❑ Molina ❑ Coordinated Care
❑ Private ❑ Other:
❑ Tricare _____

**Birth Information**

Was your baby less than 6lbs.? Yes ❑ No ❑
Was your baby premature (less than 36 weeks)? Yes ❑ No ❑

*Please circle if your child has a confirmed or suspected diagnosis of any of the following:*

| | | |
|---|---|---|
| ADHD/Anxiety | Exposure to Hepatitis | Second hand smoke exposure |
| Allergy* | Frequent earaches/Infections | Seizure disorders* |
| Allergy to food* | Frequent nose bleeds | Serious illness/Injury |
| Anemia | Hearing problems | Skin conditions/Sensitivity |
| Asthma* | Heart condition* | Surgery |
| Autism Spectrum Disorder | Hospitalizations | Vision Problems |
| Bowel/Bladder problems | Hypoglycemia* | Wears hearing aid |
| Diabetes* | Parents/grandparents have chronic health problems/disorders | Wheezing* |
| Drugs or Alcohol during pregnancy | Reactive Airway Disease* | Other Serious Disorders** |

Do you have any concerns about your child's overall health?_____

_____

_____

*Indicates the need for an ***Individual Child Health Plan*** ** Indicates the need for a ***Specialized Health Care Plan***

| YES | NO | MEDICATION |
|---|---|---|
| ☐ | ☐ | Does your child take medication? |
| ☐ | ☐ | Will your child need to take medication during EHS/HS hours? (Yes indicates a need for a ***Medication Form***) |

| YES | NO | LEAD SCREENING ASSESSMENT |
|---|---|---|
| ☐ | ☐ | Has your child ever been tested for lead via finger poke or blood draw? |
| ☐ | ☐ | Has your child been exposed to lead?<br>a. Lived in a house with peeling paint built before 1978?<br>b. Has a sibling/relative or close friend with lead poisoning?<br>c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery) |

| | | |
|---|---|---|
| | | d. Lived near a smelter/battery plant/car repair shop or other lead related industry?<br>e. Have you or your family used home remedies such as azorean, greta, kohl or pavlooah? |

| YES | NO | PHYSICAL HEALTH ASSESSMENT | COMMENTS/EXPLAIN |
|---|---|---|---|
| _____ Hrs. | | How much daily, active play is your child involved in? | |
| _____ Hrs. | | How much screen time does your child spend? TV, videos, or playing video games? | |
| ☐ | ☐ | Do you have concerns about your child's physical growth? | |

| YES | NO | NUTRITION ASSESSMENT | COMMENTS/EXPLAIN |
|---|---|---|---|
| ☐ | ☐ | Do you receive WIC (PIR)? | |
| ☐ | ☐ | Do you receive EBT/SNAP benefits (PIR)? | |
| ☐ | ☐ | Does your child eat fruits and vegetables? | |
| ☐ | ☐ | Do you consider your child a choosey eater? | |
| ☐ | ☐ | Do you share meals together as a family? | |
| ☐ | ☐ | Are there any foods that your child may not eat for cultural, ethnic or religious reasons? | |
| ☐ | ☐ | Does your child eat non-food items? | |
| ☐ | ☐ | Do you have concerns about your child's nutrition or eating habits? | |
| Does your child drink from (*circle all that apply):*<br>Bottle Cup | | | |
| Does your child *(circle all that apply):*<br>Breastfeed Drink Formula Not Applicable<br>How often? _____ times/24hrs | | | |

| YES | NO | TOILETING ASSESSMENT | COMMENTS/EXPLAIN |
|---|---|---|---|
| ☐ | ☐ | Is your child toilet trained or in the process of toilet training? | |
| ☐ | ☐ | Would you like support from center staff in potty training? | |
| ☐ | ☐ | Does your child require diapers?<br>Size:_____ | |

_____ _____

Parent Signature Date

_____ _____

Health Information form Reviewed (staff signature) Date

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Additional required documents:

❑ Individual Health Plan ❑ Specialized Health Care Plan ❑ Medication Form

❑ Allergy Letter ❑ Request for Fluid Milk Substitution ❑ Request for Special Dietary Accommodations

❑ Plan for diet change due to Religious preferences