Head Start/Early Head Start Child Health History

Center _____
Child's Name: _____ ☐ M ☐ F DOB: _____
Medical Home: ☐ Medi-Cal ☐ Private ☐ None/Referred to Central Office ☐ Other (please explain) _____
Doctor's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____

Health History	Yes	No	If yes, please explain.
Did mother have any problems during pregnancy or delivery?			
Was child born more than 3 weeks early?			
Did the child have any problems at birth or during the first month of life?			
Has child ever had a serious accident (broken bones, head injuries, fall, burns, poisoning)?			Condition (Circle "Yes" or "No"): Was child hospitalized/ER visit? Y/N Was the situation resolved? Y/N
Does child have any allergies? a. When eating any foods? b. When near animals, furs, insects, dust, etc? c. When taking any medications?			Describe allergy: _____ _____ Does the child require medication? Y/N Will this medication be needed during school hours? Y/N
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
Does your child experience any of the following: a. Squinting b. Crossed eyes c. Seeing up-close d. Seeing far away			Has your child been prescribed glasses? Y/N
Does your child: a. Have trouble hearing b. Have more than 3 ear infections in one year c. Have tubes in his/her ears			
Dental History	**Yes**	**No**	**If yes, please explain.**
Has your child seen a dentist?			
Does your child have/experience: a. Pain/bleeding from teeth and/or gums b. Spots/cavities on teeth c. Broken/cracked teeth d. Foul odor from mouth			
Does your child drink from a bottle?			If "Yes", what does your child drink from a bottle?
Social Emotional Development (leave blank if not applicable for age)	**Yes**	**No**	**Please explain.**
Did your child: a. Sit by 8 months? b. Walk by 14 months? c. Use simple words by 18 months?			
Does your child currently speak in sentences?			
What words does your child use to describe: a. Bowel movements b. Urination	X	X	a. _____ b. _____
Does your child: a. Often stumble or drop things? b. Suck his/her thumb? c. Bite his/her nails			
How do you comfort your child when he/she is afraid or upset?	X	X	
Is there anything else you would like us to know about your child?			

1st Year Parent Signature _____ Date _____ 1st Year Staff Signature _____ Date _____
2nd Year Parent Signature _____ Date _____ 2nd Year Staff Signature _____ Date _____

Follow-up information is located on Family Contact Form.

Distribution: **White – Child's File** **Canary – Parent**

H/N Services 058