Child's Name _____
Program _____ Prog Year _____
1st Day Attending: _____

Reach Dane
Head Start - Early Head Start – Child Care
Health and Developmental History
0-3 year olds (pg 1 of 2)

Child's Name (First, Last) Birth date date history completed

Parent/Guardian's Name (First, Last) Parent/Guardian's Name (First, Last)

Doctor's Name Address/Clinic Date of Last Physical Exam

Dentist's Name Address/Clinic Date of Last Visit (if haven't been, date scheduled)

Is this child covered by:

o **Medical Assistance ID No.**_____
Copy 10 digit MA# from bottom of Forward Card

HMO:
o Unity o Dean o GHC o P+ o Straight
o Benchmark
o Unsure o Other (name):

o **Applying for Medical Assistance**
o **Applying for Private Insurance**

o **Private Medical** Company:_____
Account #: _____
HMO, if any?
o Unity o Dean o Physician's Plus o GHC
o Other _____

o **Private Dental** Company: _____
Account #: _____
HMO, if any?
o Unity o Dean o Physician's Plus o GHC
o Other _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. Where was this child born? (city or country)			
2. Did mother have any health problems during this pregnancy or delivery? Did she take drugs or alcohol then?			
3. Was child born more than 3 weeks early or late? Type of delivery: □ vaginal □ C-section			
4. What was child's birth weight? Length?			Lbs. Oz Inches
5. Was anything wrong with child at birth or in the nursery?			
6. Did the child come home from hospital with the mother? If no, how long did he/she stay? In the NICU?			
HOSPITALIZATION: Has this child:			
1. Ever been hospitalized or operated on?			
2. Ever had a serious accident? (broken bones, car accident, head injury, falls, burns, poisoning)			
3. Ever had a serious illness? Describe:			
HEALTH CONCERNS			
1. Does this child have frequent: (circle) colic, sore throats, coughs, bladder/urinary infections, eating/stomach problems, vomiting, diarrhea or constipation			
2. Does your child have any vision/eye problems? (Squints, weak muscles, etc.)			
3. Is child wearing (or supposed to wear) glasses? If yes, give doctor and exam date. *Staff: remember to do release form for eye dr.*			Eye Doctor: Date of last exam:

Health and Developmental History 0-3 Year olds

Child's Name _____
Program _____

	YES	NO	EXPLAIN "YES" ANSWERS
4. Does child have any ear/hearing problems? (frequent infections, pain, etc.)			
5. Does child currently have, or ever had, "tubes" in the ears?			
6. Has child ever had a convulsion or seizure? When was the last seizure? Is child on medication now for seizures?			Date: Name of medication:
7. Is child taking medication NOW for any reason? Why? *Staff, remember to complete Medication Authorization form*			
8. Has child had: *(circle)* scarlet fever, asthma, bleeding problems, diabetes, heart murmur, heart disease, liver disease, respiratory/lung disease, sickle cell disease, lead poisoning, intestinal parasites, failure-to-thrive, speech/language problems			
9. Do family/friends smoke in your home or car while children are present?			
10. Has child had chicken pox disease?			Year: If no – Varicella shot required
11. Does child have any allergies? to food, to medication, to animals, to plants, trees, grass, insects, bee stings? (circle all that apply)			
12. If yes in 11 above, does this child have "Epi-pen" for allergic reactions? Has "Epi-pen" or "Medic-Alert" bracelet ever been suggested by a doctor?			
13. Does this child have any other serious disease or conditions? Please describe:			
14. Do you feel your child's overall growth and development is about the same as other children the same age? If no, please describe:			
15. Does this child: suck thumb, twist hair, bite fingernails, have temper tantrums, hurt self in other ways (circle)			
16. Do you have any particular concerns about your child's emotional development? (seems excessively shy, aggressive, withdrawn)			
17. Has child ever seen or experienced abuse, violence, or trauma? Please describe:			
18. Has your child had any previous child care experience?			
19. If yes, how would you describe your child's experience there?			
20. Did/does your child have any separation or adjustment concerns? Please describe:			
21. Does your child have a history of physical, sensory, or cognitive disabilities? If yes, describe:			
22. Does your child receive services from a therapist or Birth - 3 person? *Staff, please get release of information signed.*			Who: For what:

DENTAL HISTORY

1. Has child ever been to the dentist: (encouraged by age 1yr or 1st teeth)	Dentist: Date:
2. Does your child have a toothbrush? Yes or No	How often used?
3. Does child: complain of toothaches, have cavities, holes, black spots, have missing teeth due to injury? (circle all that apply)	
4. Do you use private well water? Yes or No If using well water, has the well been tested for: Bacteria _____	Take fluoride pills? Yes or No Nitrates _____ Fluorides _____

Reach Dane, operating Project Head Start, is a non-profit corporation and does not discriminate in the administration of its program.