CHILD HEALTH HISTORY
** CONFIDENTIAL **

Child's Name: _____ Birth date: _____ Male ☐ Female ☐ **FOSTER** ☐

Parent/Guardian: _____ **W.I.C. Services:** Yes ☐ No ☐ **Insurance**: Medi-Cal ☐ Private Pay ☐ None ☐

2nd Year Parent Initial _____ Date _____ **W.I.C. Number:** _____ **Medical Plan**: _____

Dental Plan: _____

1. INFANT/CHILDHOOD HEALTH		
Child's birth weight	lbs.	oz.
Check Yes or No	**Yes**	**No**
Premature birth		
Feeding problems/poor weight gain		
Breathing difficulty		
Did child walk by 14 months?		
Did child speak single words by 15 months?		
Was child exposed to drugs/alcohol/tobacco smoke during		
Is child exposed to secondhand smoke now?		
Has child had serious illness/injury, been hospitalized overnight or had surgery?		

2. MEDICATIONS		
Is child currently taking:	**Yes**	**No**
Fluoride		
Vitamins		
Iron		
Prescribed medication(s)-please list:		

3. Check the "Family" column if there is a history of the following conditions in your family. Check the "Child" column if it applies to your child.		
	Family	**Child**
Allergies		
Anemia		
Asthma		
Seizures / Epilepsy		
Diabetes		
Drug reactions		
Overweight/Obesity		
Alcohol / Substance abuse		
Autism / PDD / Asperger's		
Developmental or intellectual delays		
Sickle Cell disease		

4. Has the child had any of the following:	**Yes**	**No**
Vision problems		
Wears glasses		
More than 3 ear infections/year		
Tubes in ears		
Frequent constipation/diarrhea/stomach		
More than 3 colds/year		
Pneumonia		
Eczema		
Cerebral Palsy		
Fractures		
Teeth/gums/mouth problems		
Can you understand most of what your child says?		
Are you concerned your **child**'s **ability to talk or understand is very delayed?**		

5. Toilet Training	**Yes**	**No**
Child expresses the need to go and can ask to use the toilet.		
Child is able to walk to toilet, pull down clothing, get on & off toilet without assistance.		
Child wears a diaper or pull-up.		
Child has 2 or more toileting accidents each day.		

6. DENTAL CARE HISTORY		
Are child's teeth:	**Yes**	**No**
Brushed daily by parent		
Brushed daily by child		
Flossed daily by parent		
Seen by dentist within past year		

Is there any health information or concern you would like us to know about your child?

6. NUTRITION HISTORY:	**Yes**	**No**
Is child on a special diet for medical reasons?		
Is child allergic to any foods?		
Is there any food child should not eat for religious/personal reasons?		
Does child eat/chew things that are not food?		
Do you have any concerns about child's eating habits?		
Does child drink from a baby bottle?		
How many times a day does child have? Meals: Snacks:		
Would you describe child's diet as Good ☐ Fair ☐ Poor ☐		

7. **How many times a day does child eat the following?**

Foods	#
Meat, fish, poultry, eggs	
Dried beans, lentils, peanut butter	
Fruits	
Vegetables	
Milk	
Cheese, yogurt	
Bread, rice, grits, cereal, tortillas	
Sodas/sweetened fruit drinks	
Cake, cookies, candy, chips	

FOR STAFF TO COMPLETE ONLY:	**Yes**	**No**
Does child need medication at school?		
Medication Form provided.		
Does child need an emergency health plan?		
School nurse to be notified at enrollment.		
Does child require a special diet for medical reasons?		
Food/Nutrition Services Medical Statement Form provided.		
Is family requesting an alternate meal plan for religious/personal reasons?		
Alternate Meal Form provided.		

ANY "YES" ANSWER MUST BE ADDRESSED:

Parent/Guardian Signature: **Date:**

Staff Signature: **Date:**