COMMUNITY ACTION OF SOUTHEAST IOWA
CHILD HEALTH HISTORY

Child's Name: _____ **Sex:** _____ **Birthdate:** _____

	Review answers and note any changes below
Primary Health Questions	
Does your child have a physician? Yes _____ No _____ Doctor's Name:_____ Does your child have a dentist? Yes _____ No _____ Dentist's Name:_____	
Does your child have medical insurance? Yes _____ No _____ Does your child have dental insurance? Yes___ No___	
Is your child supposed to wear glasses? Yes _____ No _____ Eye Doctor's Name:_____ When did your child get his/her last set of glasses? _____/_____/_____	
Medical/Doctor-Related Questions	
Has your child ever had any of the following concerns? Low Hemoglobin _____ High Lead Level _____	
Does your child have asthma? Yes _____ No _____ If yes, please explain: _____ Does your child take a prescribed medication for this illness? _____	
Does your child have seizures? Yes _____ No _____ If yes, please explain: _____ Does your child take a prescribed medication for this illness? _____	
Does your child have any allergies? Yes _____ No _____ (food allergies will be addressed on the Nutrition Assessment) Seasonal _____ (summer, spring, winter, fall) Environmental _____ (mold, pollen, sun, dust) Pets _____ (dog, cat) Medications _____ (Penicillin, Tylenol) Insect Bite/Sting _____ (bee, wasp, mosquito) Other _____ (soap, detergent, latex, etc.) Symptoms: _____ Has this been diagnosed by a physician? Yes _____ No _____	
Does your child require medication at school (listed below)? Yes _____ No _____ Albuterol _____ Epi Pen _____ Inhaler _____ Other _____ If other, list medicine: _____	
Does your child have a diagnosed or suspected disorder (listed below)? Yes _____ No _____ ADD/ADHD _____ ODD _____ Autism _____ Other _____ If other, please explain: _____	
Has your child ever had a serious accident, illness or hospitalization? Yes _____ No _____ (Example: broken bones, head injuries, fall, burns, poisoning, etc.) If yes, please explain: _____	
Special Needs/Considerations Questions	
Does your child receive special services from AEA/School System through an IEP or IFSP? Yes _____ No _____ What is the IEP/IFSP for? Speech Therapy _____ Developmental Delays _____ Physical/Occupational Therapy _____ Hearing Assistance _____	
Does your child have any physical disability or impairment? Yes _____ No _____ (Example: wheel chair, loss of hearing or sight, cerebral palsy, paralysis, spina bifida, etc.) If yes, please explain: _____	
Does your child have any skin/medical conditions? Yes _____ No _____ (Example: eczema, dermatitis, hemophilia, sickle cell disease, failure to thrive, MRSA, etc.) If yes, please explain: _____	
Has a doctor ever mentioned having any concerns about your child's development? Yes _____ No _____ If yes, please explain: _____	
Are there any safety-related concerns for your child? Yes _____ No _____ (Example: running away, harming self, others or animals, etc.) If yes, please explain: _____	
How many hours of sleep does your child get each night? _____ Bedtime _____ Wake time _____	
Are there any behavior concerns for your child? Yes _____ No _____ (Example: aggression, tantrums, non-compliance, self-stimulating, etc.) If yes, please explain: _____	
Are there any concerns for your child's mental health? Yes _____ No _____ (Example: anxiety, depression, phobias, past abuse or neglect, etc.) If yes, please explain: _____	
Is there anything else we should know about your child to help him/her succeed in school? Yes _____ No _____ (Example: potty training, fears, etc.) If yes, please explain: _____	

Process

1. During the time of application to the program, a Family Development Specialist will assist the family in the completion of this form and will ask any questions needed to achieve clarification as to a child's condition and/or needs.
2. After the assessment is completed, the Nurse will then review the document to make sure there are no other questions or cause for concern. If any, the Nurse will discuss them with the Family Development Specialist.
3. Before a child begins attending, a Home Visit will be completed with a Family Development Specialist. At that time, the staff member will **update** the form with the family to make sure there have been no changes. If there are any changes, the Family Development Specialist will notify the Lead Teacher, the RN and the Health Services Coordinator (if necessary).

Staff Signature: _____ **Date:** _____/_____/_____

Nurse Review: _____ **Date:** _____/_____/_____

UPDATED: _____ **Date:** _____/_____/_____

COMMUNITY ACTION OF SOUTHEAST IOWA
PRENATAL/BIRTH HISTORY

Child's Name: _____ Sex: _____Birthdate:_____

Prenatal Health
Did mother have any health problems during pregnancy? Yes____ No_____ Specify:_____
Did mother receive prenatal care? Yes____ No_____ What trimester: Before First___ First___ Second___ Third____
Did mother consume any of the following during pregnancy? (circle all that apply) Alcohol Caffeine Tobacco Prescription/non-prescription Illicit Drugs
Postnatal Health
Was child born more than 3 weeks early or 3 weeks late? Yes____ No____
Were there any complications with delivery or child at birth? Yes____ No_____ Specify:_____
Are there any observable birth defects or birthmarks? Yes____ No_____ Description and location:_____
Did mother or child stay in the hospital longer than 1-2 days? Yes____ No_____ Specify:_____

- What was child's birth weight and length? _____ lbs. _____oz._____inches
- Where was child born? _____
- Did child receive newborn hearing screen? Yes___ No___ Did child pass screening? Yes__ No___

Staff Signature: _____ Date: _____/_____/_____

Nurse Review: _____ Date: _____/_____/_____