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Wayne County Head Start
Child's Health Record

Child's Name: **Today's Date:** ____________________

Child's Date of Birth: **Information provided by:** ____________________

Child's Sex: [ ] Male [ ] Female **Relation to child:** ____________________

Child's Birth Weight ________ lb. ______ oz. ________ Child's Birth Place: ____________________

Child's birth was [ ] at due date; [ ] 3 weeks early; [ ] 3 weeks late example: Michigan

Explain any problems with mother or child during pregnancy or delivery

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1 In the past year has this child had any of the following conditions? [ ] Yes [ ] No
If yes, please check the condition(s). Please comment on any checked condition.

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☐ Allergies	☐ Anemia (low iron)	☐ Asthma	☐ Boils
☐ Bleeding Condition	☐ Broken Bones	☐ Cancer	☐ Chicken Pox
☐ Diabetes	☐ Eczema	☐ Hives	☐ Heart Disease
☐ High Blood Pressure	☐ High Lead	☐ Mumps	☐ Measles
☐ Immune System Disease	☐ Inherited Disease	☐ Liver Disease	☐ Seizures
☐ Mental Retardation	☐ Mental Illness	☐ Overweight	☐ Pneumonia
☐ Sickle Cell Disease	☐ Sickle Cell Trait	☐ Tubes in Ears	☐ Tonsils Removed
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Underweight	☐ Other:

2 Is child receiving treatment for any of the following conditions? [ ] Yes [ ] No
If yes, please check the condition(s).

☐ Anemia (low iron)	☐ Asthma	☐ Overweight	☐ Hearing Difficulties
☐ Vision Problems	☐ High Lead Level	☐ Diabetes	
☐ Other:			

3 Is the child currently taking any medication? [ ] Yes [ ] No (A medication consent form must be completed and signed by a doctor for a child to receive any medication while at any Head Start program.)

Name of medication: ____________________

Dose: ____________________

How often? ____________________

4 If your child has a health problem, has it been diagnosed by a doctor or health care professional?
[ ] Yes [ ] No If yes, please explain. List the name/address of the doctor/specialist:

____

____

5 Has the child ever had surgery? [ ] Yes [ ] No
If yes, please check the condition(s).

____

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6 Has the child ever has a seizure? [ ] Yes [ ] No
If yes, please explain how often, cause (if known) and date of last seizure.

____

7 Has the child ever been diagnosed with asthma? [ ] Yes [ ] No
If yes, please explain how often, causes (if known) and date of last asthma attack.

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8 Has the child ever had an allergic reaction? [ ] Yes [ ] No
If yes, please explain to what and please explain the reaction.

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9 Has the child ever had problems with the following?
Please check the condition(s).

[ ] Frequent Ear Infections	[ ] Frequent Sore Throats	[ ] Frequent Bed-wetting
[ ] Frequent Fevers	[ ] Frequent Cough	[ ] Frequent Stomach Ache
[ ] Frequent Chest Pains	[ ] Frequent Colds	[ ] Problems with Urine
[ ] Problems with Bowels	[ ] Problems Eating	[ ] Problems with Teeth
[ ] Problems Hearing	[ ] Problems with Seeing	[ ] Eye Problems
[ ] Frequent Trouble Sleeping	[ ] Speech Problems	[ ] Temper Tantrums

[ ] Other Frequent Problems: ______________________________

10 Has the child ever been involved in a child abuse or neglect incident or case? [ ] Yes [ ] No
If yes, please explain. ______________________________

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11 Does your child have any additional conditions that interfers with his/her daily activities? [ ] Yes [ ] No
If yes, please explain. ______________________________

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12 Is the child's routine screenings (Developmental, Sensory and Behavioral) completed? [ ] Yes [ ] No
If yes, specify completion date: ______________________________

If yes, did child need follow-up assessment or formal evaluation? [ ] Yes [ ] No

13 Does your child currently have an Individual Education (IEP) or Individual Family Service Plan (IFSP)?
[ ] Yes [ ] No What school district completed the IEP/IFSP? ______________________________

14 Do you have a regular doctor for your child? [ ] Yes [ ] No
If your child has a regular doctor, when did you obtain a doctor? Before enrollment? [ ] Yes [ ] No
Where does your child receive medical care? Please give doctor's name, address and phone number.
Name: ______________________________
Address: ______________________________
____
Phone number: ______________________________

15 Do you have a regular dentist for your child? [ ] Yes [ ] No
If your child has a regular dentist, when did you obtain a dentist? Before enrollment? [ ] Yes [ ] No
Where does your child receive dental care? Please give dentist's name, address and phone number.
Name: ______________________________
Address: ______________________________
____
Phone number: ______________________________

16 Has child had professional dental exam completed? [ ] Yes [ ] No
If yes, specify completion date ____________________

17 Did the child receive preventative care? [ ] Yes [ ] No

18 Does the child need follow up dental treatment? [ ] Yes [ ] No

19 Has the child completed dental follow up treatment? [ ] Yes [ ] No If yes, date: ____________________

20 Do you need a referral for a doctor or dentist? [ ] Yes [ ] No

21 Please indicate type of your child's insurance:

Medical	**Dental**
[ ] Medicaid	[ ] Medicaid
[ ] MiChild	[ ] MiChild
[ ] Healthy Kids	[ ] Healthy Kids
[ ] Other:	[ ] Other:

1st Year Comments: **Staff Signature & Date:** ____________________

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2nd Year Review & Comments: **Staff Signature & Date:** ____________________

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