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: ______________________ example: Michigan

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

Explain any problems with mother or child during pregnancy or delivery

____

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).

____

____

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.

____

____

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

____

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. ______________________________

____

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
- [ ] Medicaid
- [ ] MiChild
- [ ] Healthy Kids
- [ ] Other:

Dental
- [ ] Medicaid
- [ ] MiChild
- [ ] Healthy Kids
- [ ] Other:

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

____

____

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

____

____

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eliminating racism
empowering women
ywca

Wayne County Head Start
Child's Nutrition Record

Child's Name: ______________________ **Today's Date:** ___

Date of Birth: ______________________ **Information provided by:** ___

Relation to child: ___

Second Year Date: ___

Please answer the following questions regarding your child.

1 Is your child currently taking a vitamin supplement? [ ] Yes [ ] No
Are they prescribed? [ ] Yes [ ] No If yes, name: ______________
If yes, is it iron fortified? [ ] Yes [ ] No

2 Persistent/current nausea or vomiting? [ ] Yes [ ] No ______________

3 Persistent/current diarrhea? [ ] Yes [ ] No ______________

4 Persistent/current constipation? [ ] Yes [ ] No ______________

5 Dramatic weight change in the past year? [ ] Yes [ ] No ______________

6 Recent surgery (within 3 months)? [ ] Yes [ ] No ______________

7 Recent hospitalization (within 3 months) [ ] Yes [ ] No If yes, for ___

8 Is your child on a special diet? [ ] Yes [ ] No If yes, what diet? ___

9 Does your child have any food allergies or intolerance? What foods? ______________

____

Indicate foods your child cannot eat at school:

- [ ] Pork
- [ ] Beef
- [ ] Chicken
- [ ]
- [ ] Fish
- [ ] Cheese
- [ ] Yogurt
- [ ]
- [ ] Other: ______________

10 Do you have any other nutritional concerns?

____

11 Check nutrition program your child particpates in:

- [ ] WIC
- [ ] Food Stamps
- [ ] Other
- [ ]

12 Does your child have trouble swallowing? [ ] Yes [ ] No

13 Does your child use a spoon or fork? [ ] Yes [ ] No

14 Does your child use a feeding tube or other special feeding method? [ ] Yes [ ] No

15 Do you think your child is too

- [ ] Thin
- [ ] Small
- [ ] Heavy
- [ ]

16 Does your child currently take a bottle? [ ] Yes [ ] No

17 Does your child eat or chew on anything that is not food? [ ] Yes [ ] No
If yes, specify.

____

18 On a typical day what meals does your child eat? Check all that apply.

☐ Breakfast ☐ Lunch ☐ Snack ☐

19 How many times **in a day** does your child eat or drink a food from the following food groups?

a. Milk, cheese, yogurt
0 1 2 3 4 5 6 7 7+

b. Meat, poultry, fish, eggs or dried beans/peas, peanut butter
0 1 2 3 4 5 6 7 7+

c. Rice, grits, bread, cereal, tortillas
0 1 2 3 4 5 6 7 7+

d. Greens, carrots, broccoli, winter squash, pumpkin, sweet potato
0 1 2 3 4 5 6 7 7+

e. Oranges, grapefruit, tomatoes (fruit or juice)
0 1 2 3 4 5 6 7 7+

f. Other fruits and vegetables
0 1 2 3 4 5 6 7 7+

g. Oil, butter, lard, margarine
0 1 2 3 4 5 6 7 7+

h. Cakes, cookies, soda/pop, fruit drinks (kool-aid), candy
0 1 2 3 4 5 6 7 7+

Food Intake Total

Scoring for questions a - f:
For each food group eaten 6 or 7 X per day, give 4 points
For each food group eaten 4 or 5 X per day, give 3 points
For each food group eaten 2 or 3 X per day, give 2 points
For each food group eaten 0 or 1 X per day, give 1 point

Scoring for questions g & h:
For each food group eaten 6 or 7
For each food group eaten 4 or 5
For each food group eaten 2 or 3
For each food group eaten 0 or 1

To be completed by Head Start Staff:

Criteria for Referral:

☐ Suspect Dietary problem or suspected inadequate food intake (score 11 or below)
☐ Hemoglobin less than 11 Gm or Hematocrit 33% or below
☐ Underweight ☐ Overweight
☐ Short for age ☐ Weight for Height (>95% or <5%)
☐ No Referral Needed

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

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

Turkey
Eggs

None

Tall

Dinner

X per day, give 0 points
X per day, give 0 points
X per day, give 0 points
X per day, give 2 point