

# Early Childhood Health Information Form

Date: \_\_\_\_\_ Completed by \_\_\_\_\_

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth date \_\_\_\_\_

Is your child attending: (circle) Day Care, Head Start, ECFE, PreSchool, Other \_\_\_\_\_

Where and how often \_\_\_\_\_

Date of last dental appointment \_\_\_\_\_

Health insurance?  Yes  No Name of plan \_\_\_\_\_

Child's Doctor and Clinic \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

What clinic(s) or health care provider(s) gave your child's immunizations? \_\_\_\_\_

Please enter the dates your child received each immunization, or attach a copy of child's immunizations.

Type of Vaccine	1 <sup>st</sup> Dose Mo/Day/Yr	2 <sup>nd</sup> Dose Mo/Day/Yr	3 <sup>rd</sup> Dose Day/Yr Mo/	4 <sup>th</sup> Dose Mo/Day/Yr	5 <sup>th</sup> Dose Mo/Day/Yr
<b>Diphtheria, Tetanus, and Pertussis</b> (DtaP, DTP)					*
<b>Polio</b> (IPV, OPV)				*	
<b>Measles, Mumps and Rubella</b> (MMR)		*			
<b>Hepatitis B</b> (heb B)** (Comvax)					
<b>Haemophilus influenzae type b</b> (Hib)*** (Comvax)					
<b>Varicella</b> (chickenpox)					
<b>Pneumococcal Conjugate</b> (PCV)*** (Pevnar)					

\*Usually given at 5-year check-up.

\*\*Hepatitis B is required for Kindergarten and 7<sup>th</sup> grade.

\*\*\*PCV and Hib vaccines are recommended only for children through age 4 years.

**Please check the box(es) if you have concerns or questions about your child's:**

- |   |                                       |  |   |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> general appearance | <input type="checkbox"/> headache     | <input type="checkbox"/> skin/bruising, rashes | <input type="checkbox"/> activity level   |
| <input type="checkbox"/> health             | <input type="checkbox"/> eyes/vision  | <input type="checkbox"/> breathing/coughing    | <input type="checkbox"/> behavior         |
| <input type="checkbox"/> growth             | <input type="checkbox"/> ears/hearing | <input type="checkbox"/> walking/balance       | <input type="checkbox"/> social (friends) |
| <input type="checkbox"/> development        | <input type="checkbox"/> throat       | <input type="checkbox"/> toileting             | <input type="checkbox"/> feelings/moods   |
| <input type="checkbox"/> nutrition          | <input type="checkbox"/> teeth        | <input type="checkbox"/> speech                |   |

other \_\_\_\_\_

comments \_\_\_\_\_

## Health

**Please check the box(es) that apply to your child and explain:**

- Allergies to foods and/or medicines \_\_\_\_\_
- Asthma \_\_\_\_\_
- Takes medicines, herbs, and/or vitamins \_\_\_\_\_
- Visits to health specialists or therapists \_\_\_\_\_
- Serious illnesses \_\_\_\_\_
- Serious injuries or loss of consciousness \_\_\_\_\_
- Hospital stays and/or surgeries \_\_\_\_\_
- Problems during birth or mother's pregnancy \_\_\_\_\_
- At birth, stayed in the hospital longer than mother \_\_\_\_\_
- Was adopted. (What age and from what country?) \_\_\_\_\_
- Evaluated for or received therapy for special learning or developmental concerns \_\_\_\_\_

**Members of the same family sometimes have similar conditions or concerns.**

**Check if the parents, brothers, or sisters of child have:**

- Vision impairment      Who: \_\_\_\_\_
- Hearing impairment      Who: \_\_\_\_\_
- Mental illness      Who: \_\_\_\_\_
- Learning problems      Who \_\_\_\_\_

## Home

**Please check all boxes that describe your child:**

Does your child live or play in a home or building built before:  1950  1978 and is being remodeled?

Does anyone in your home or who cares for your child:  use tobacco  use alcohol  have a gun?

Do you:  have smoke detectors?  have carbon monoxide detectors?  
 use seat belts?  have the Poison Control Number?

**Do you want information or have questions about:**

- Child Care       Food       Early Childhood Programs
- Transportation       Clothing       Recreational programs
- Housing       Lead poisoning       Adult reading programs, (GED, ESL)
- Other \_\_\_\_\_

**Parent Comments:**

- 1. The things I like most about my child are:
  
- 2. Things about raising my child that are challenging:
  
- 3. I would like my child to learn or get better at:
  
- 5. When I need help with my family, I usually:
  
- 6. Has any member of your family witnessed or experienced family or neighborhood violence?  
Yes    No    If **YES**, explain:
  
- 7. Has there been unusual stress in your family that might affect your child?  
(Examples--new brother or sister, divorce, death, move, financial problems, not enough food, etc.).
  
- 8. Is there anything else you would like to discuss?

<b>Please List All Family/Household Members Including Adults and Children:</b>				
Name	Relationship to Child	Birth Date	Male/Female	Lives at Home