

NOCAC HEAD START – ECE PRESCHOOL
HEALTH/DENTAL/DIETARY HISTORY FORM

Child's Name _____

Date of Birth _____

HEALTH HISTORY

Date of last well child exam _____

Name of Medical Home Facility/Doctor _____

Birth weight _____

Received Prenatal care - Yes or No

Mother's health during pregnancy _____

Tobacco Use during Pregnancy Yes or No

Alcohol Use during Pregnancy Yes or No

Check any of the following which have been a problem for any member of your family, including grandparents:

___ mental retardation ___ skin allergies ___ heart disease ___ birth defects ___ asthma
___ epilepsy ___ cancer ___ diabetes ___ convulsions ___ None apply

Other _____

Did your child have problems at birth? (i.e. jaundice, oxygen needed, didn't cry, etc.) _____

Please mark the following conditions that apply to your child with an "E", "P" or "L"

(indicating Existing, Past or Life Threatening condition)

___ Allergic Condition ³	___ Bowel/bladder accidents	___ Heart trouble
___ Asthma	___ Bone/orthopedic	___ Neurological problems
___ Drugs	___ Constipation/diarrhea/food intolerance	___ Seizures with/without Fever
___ Covid-19 ³		
___ Foods	___ Diabetes	___ Serious accident/injuries
___ Insects	___ Eczema/skin condition	___ Surgery/hospitalization
___ Latex	___ Eating/swallowing difficulties	___ Urinary tract infections
___ Pollens/dust	___ Exposure to TB/respiratory disease	___ Vision: wears glasses/patch
___ Cancer	___ Anemia/sickle cell/blood disease	___ Hearing/ear problems
___ Other _____		

Please explain the **LIFE THREATENING**¹ or any Existing conditions³: _____

Do you have any concerns about your child's health? Yes No If yes, what? _____

Does your child take any medicine (vitamins, prescription or over the counter) on a regular basis? Yes No

If yes, what? _____

Will it need to be given to your child at school? Yes^{2 or 3} No

Does your child have special needs or need help to participate in classroom activities (i.e. help with toileting, etc.)?

Yes³ No If yes, what? _____

Has your child ever been tested with a finger stick (poke) for lead or hemoglobin? Yes No

When _____ Where _____

FOR STAFF USE: REFERRALS: a - Health Manager b - Dietitian c - WIC/Health Insurance-FA

1-Complete ROI 2- Complete Med Administration Plan 3- Complete Medical Care Plan

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DENTAL HISTORY

Date of last dental exam _____ Dental Home/Name _____ My child does **NOT** have a dentist.
Has your child ever had any cavities? Yes No If yes, have they been fixed? Yes No
Does your child brush his/her teeth daily? Yes No
Do you help brush his/her gums/teeth? Always Sometimes Never
Does your child drink from a bottle or spill-proof cup at bedtime/naptime? Yes No If yes, content _____
Do you have concerns about your child's teeth? Yes No If yes, explain _____
Do you have family dental concerns? Yes No If yes, explain _____
Does your house receive water from the city water supply, well, pond or cistern? Please circle which applies.
Does your family drink tap water? Yes ____ No ____ Does your family drink bottle water? Yes ____ No ____

DIET HISTORY

Does your family restrict any foods for religious, cultural, ethical or personal reasons?
 Yes^b No If yes, what foods and why? _____
Does your child have any chewing or swallowing problems?
 Yes^a No If yes, explain _____
Do you have any concerns about what your child eats or weighs?
 Yes^b No If yes, explain _____
Does your child refuse to use silverware, throw food, or do other things that upset your meal time? Yes No
Explain _____
Does your child have a problem using: ____ fork ____ spoon ____ knife ____ cup (check all that apply)

Women Income & Children

WIC is a nutrition education program which provides nutritious supplemental foods for postpartum women, breastfeeding mothers, infants and children up to age 5. Some examples of possible supplemental foods provided are baby formula, milk, eggs, cheese, and cereal.

Are you interested in receiving WIC services?

____ Yes, I already receive WIC. ____ No, but I would like to receive WIC.^c

____ No, I am not interested in WIC because _____

Do you currently have health insurance? Yes ____ No ____^c

The information provided on this form is accurate and true to the best of my knowledge.

Parent/legal Guardian Signature

Date

Head Start Staff Signature

Date

Center Site _____ Classroom _____

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