Skagit/Islands Head Start & ECEAP
HEALTH INFORMATION (BIRTH - 5 YEAR)

Childs Name	Sex: F ❑ M ❑	Birthdate:

Childs Health Care Provider: _____

Child's Dentist: _____

Date of last Well Child: ___ / _____ (Month Year) Date of last Dental Exam: ___ / _____ (Month Year)

Health Insurance Medical & Dental:
(check one)

❑ Apple Health ❑ CHPW
❑ Molina ❑ Coordinated Care
❑ Private ❑ Other: _____
❑ Tricare

Birth Information

Was your baby less than 6lbs.? Yes ❑ No ❑
Was your baby premature (less than 36 weeks)? Yes ❑ No ❑

Please circle if your child has any of the following:

Allergy*	Frequent earaches/Infections	Second hand smoke exposure
Allergy to food*	Frequent nose bleeds	Seizure disorders*
Anemia	Hearing problems	Serious Illness/Injury
Asthma*	Heart condition*	Surgery
Bowel/Bladder problems	Hospitalizations	Vision Problems
Diabetes*	Hypoglycemia*	Wears hearing aid
Drugs or Alcohol during pregnancy	Parents/grandparents have chronic health problems/disorders	Wheezing*
Exposure to Hepatitis	Reactive Airway Disease (R.A.D)*	Other Serious Disorders**

Do you have concerns about your child's overall health or development? _____

_____

_____

_____

_____

_____

*Indicates the need for an ***Individual Child Health Plan*** ** Indicates the need for a ***Specialized Health Care Plan***

YES	NO	MEDICATION
☐	☐	Does your child take medication?
☐	☐	Will your child need to take medication during EHS/PHS/ECEAP hours? (Yes indicates a need for a ***Medication Form***)

YES	NO	LEAD SCREENING ASSESSMENT
☐	☐	Has your child ever been tested for lead via finger poke or blood draw?
☐	☐	Has your child been exposed to lead? a. Lived in a house with peeling paint built before 1978? b. Has a sibling/relative or close friend with lead poisoning? c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery) d. Lived near a smelter/battery plant/car repair shop or other lead related industry? e. Have you or your family used home remedies such as azorean, greta, kohl or pavlooah?

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YES	NO	PHYSICAL HEALTH ASSESSMENT	COMMENTS/EXPLAIN
_____ Hrs.		How much daily, active play is your child involved in?	
_____ Hrs.		How much screen time does your child spend? TV, videos, or playing video games?	
☐	☐	Do you have concerns about your child's physical growth?	

YES	NO	NUTRITION ASSESSMENT	COMMENTS/EXPLAIN
☐	☐	Do you receive WIC?	
☐	☐	Do you receive EBT/SNAP benefits?	
☐	☐	Does your child eat fruits and vegetables?	
☐	☐	Do you consider your child a choosey eater?	
☐	☐	Do you share meals together as a family?	
☐	☐	Are there any foods that your child may not eat for cultural, ethnic or religious reasons?	
☐	☐	Does your child eat non-food items?	
☐	☐	Do you have concerns about your child's nutrition or eating habits?	
Does your child drink from: *(circle all that apply)* Bottle Cup			
Does your child: *(circle all that apply)* Breastfeed Drink Formula Not Applicable How often? _____ times/24hrs			

YES	NO	TOILETING ASSESSMENT	COMMENTS/EXPLAIN
☐	☐	Is your child toilet trained or in the process of toilet training?	
☐	☐	Would you like support from center staff in potty training?	
☐	☐	Does your child require diapers? Size:_____	

_____ _____

Parent Signature Date

_____ _____

Health Information form Reviewed (staff signature) Date

FOR OFFICE USE ONLY

Additional required documents:

❑ Individual Health Plan ❑ Specialized Health Care Plan ❑ Medication Form

❑ Allergy Letter ❑ Request for Fluid Milk Substitution ❑ Request for Special Dietary Accommodations

❑ Plan for diet change due to Religious preferences