CHILD HEALTH RECORD: FORM 1, GENERAL INFORMATION

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

NAME OF INTERVIEWER:_____ TITLE:_____

1. PERSON INTERVIEWED_____
   DATE_____, RELATIONSHIP TO CHILD_____
2. CHILD'S NICKNAME, IF ANY_____
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   _____
   _____ Zip Code _____
   PHONE _____
4. FATHER'S NAME_____
5. MOTHER'S NAME_____
6. GUARDIAN'S NAME_____
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   _____
   PHONE_____, RELATIONSHIP_____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   _____English _____Spanish
   _____Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES NO EPSDT/Medicaid (Latest certification No.):
   _____
   YES NO Federal, State or Local Agency:
   _____
   YES NO In-Kind Provider:_____
   YES NO Other (3rd party):_____
   ID NO.:_____
   YES NO WIC
   YES NO Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    _____
11. DATE OF LAST VISIT TO DENTIST
    _____

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE
    (Name, address, and phone no.):
    Physician _____
    _____
    Clinic _____
    _____
    Hospital ER_____
    _____
    Other _____
    _____
    Dentist _____
    _____
13. IN CASE OF EMERGENCY NOTIFY
    (1) _____
    Relationship _____
    Phone _____ or _____
    (2) _____
    Relationship _____
    Phone _____ or _____
    (3) _____
    Relationship _____
    Phone _____ or _____
14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites_____
    - ☐ Allergy, Medication_____
    - ☐ Other_____
      _____

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER				
MOTHER				
BROTHERS & SISTERS *(oldest first)*				
(1)				
(2)				
(3)				
OTHER *(Specify relationship)*				
(1)				
(2)				
(3)				

(Use additional page if needed)

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

INTERVIEWER: GO TO FORM 2A

CHILD HEALTH RECORD: FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER: _____

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

PERSON INTERVIEWED: _____ DATE: _____ RELATIONSHIP: _____

NAME OF INTERVIEWER: _____ TITLE: _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS CHILD'S BIRTH WEIGHT?			_____ lbs., _____ oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)?*			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUENT ___SORE THROAT; _____COUGH; ____URINARY INFECTIONS OR TROUBLE URINATING, ____STOMACH PAIN, VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)?*	*		
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?			*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?*	*		
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?			
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*		*If "yes" ask:* WHEN DID IT LAST HAPPEN?_____ WHAT MEDICINE?_____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*			WHAT MEDICINE?_____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START?_____HOW OFTEN?_____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			(PHYSICIAN'S NAME:_____)
21. HAS CHILD HAD: ___BOILS, ___CHICKENPOX, ___ECZEMA, ____GERMAN MEASLES, ____MEASLES, _____MUMPS, ___SCARLET FEVER, _____WHOOPING COUGH?			
22. HAS CHILD HAD: ___HIVES, ____POLIO?	*		
23. HAS CHILD HAD: ___ASTHMA, ____BLEEDING TENDENCIES ___DIABETES, ____EPILEPSY, ____HEART/BLOOD VESSEL DISEASE, ___LIVER DISEASE, ____RHEUMATIC FEVER, ____SICKLE CELL DISEASE?	*		*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)?* a. WHEN EATING ANY FOODS?_____ b. WHEN TAKING ANY MEDICATION?_____ c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.?_____	*		*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

* *If starred (*) questions have "yes" answers, go to question 25.*

INTERVIEWER: GO TO FORM 4

CHILD HEALTH RECORD: FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED:_____ DATE: _____ RELATIONSHIP: _____

NAME OF INTERVIEWER:_____ TITLE: _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____NO, _____YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____NO, _____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____NO, _____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO _____EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO _____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____NO, _____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

CHILD HEALTH RECORD: FORM 6, NUTRITION

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE?_____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES?

	Yes	No
3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS?		
(a) If "yes", what kind are they? _____		
(b) Do they contain iron?		
(c) Do they contain fluoride?		
(d) Were they prescribed?		
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS?	*	
5. IS YOUR CHILD ON A SPECIAL DIET?	*	
(a) What kind? _____		
6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH?	*	
7. DOES YOUR CHILD TAKE A BOTTLE?	*	
8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD?	*	
9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING?	*	
10. DOES YOUR CHILD OFTEN HAVE:		
(a) Diarrhea?	*	
(b) Constipation?	*	
11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?	*	

12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?

Approximate Number of Times a Week *(circle the number(s) nearest to parent's answer)*

(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 potatoes.	0*	1*	2	3	4	5	6	7	7+
(e) Oranges, grapefruit, tomatoes (fruit/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, margarine, lard.	0*	1*	2	3	4	5	6	7	7+*
(h) Cakes, cookies, sodas, fruit drinks, candy.	0	1	2	3	4	5	6	7	7+*

*****Starred answers may require follow-up. Explain details or give additional comments here.*

PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST

13. GROWTH

DATE	AGE	HEIGHT *(no shoes, to nearest 1/8 in.)*	WEIGHT *(light clothing, to nearest 1/4 lb..)*
	_____yrs._____mo.		
	_____yrs._____mo.		
	_____yrs._____mo.		

14. ANEMIA SCREEN

	DATE	HEMOGLOBIN*	OR HEMATOCRIT *
SCREENING			
RESCREENING			

*****Hgb less than 11 or Hct less than 34 require follow-up*

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION

(Review items 2 through 13. If there are answers in starred (*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)

- ☐ Suspect dietary problem or inadequate food intake *(from Questions 2 to 12)*
- ☐ Hgb. less than 11 gm. or Hct. less than 34% *(from Question 14)*
- ☐ Underweight *(weight less than typical, from Growth Chart 1 or 4)*
- ☐ Overweight *(weight greater than typical, from Growth Chart 1 or 4)*
- ☐ Short for Age *(height less than typical, from Growth Chart 2 or 5)*
- ☐ Wt. for Ht. *(greater or less than typical, from Growth Chart 3 or 6)*

COMMENTS *(use additional page if needed)*

Signature_____ Title_____ Date_____