Alachua County Public Schools
Early Intervention Services
Head Start

Health Staff Complete
Site: _____
Classroom: _____

CHILD HEALTH RECORD

Child's Name: _____ **Sex:** ☐ **female** ☐ **male** **Birth Date:** _____

Health History	YES	NO	EXPLAIN "YES" Answers
1. Does your child have a doctor/clinic?	☐	☐	Doctor: _____ Clinic: _____
2. Does your child have health insurance?	☐	☐	If yes, what type: (check all that apply) ☐ Medicaid # _____ ☐ Private (list) _____
3. Does your child have a dentist?	☐	☐	Dentist:
4. Has your child been seen by a dentist?	☐	☐	Last visit:
5. Does your child have dental insurance?	☐	☐	If yes, what type: (check all that apply) ☐ Medicaid # _____ ☐ Private (list) _____
6. Is your child being seen by a specialist?	☐	☐	Doctor: _____ Clinic: _____
7. Is your child taking any medication now?	☐	☐	What? _____ For? _____
8. Will he/she need medication at school?	☐	☐	
Physical, Emotional, Social Development	**YES**	**NO**	**EXPLAIN "YES" Answers**
9. Can you tell us one or two things your child is interested in or does especially well?			
10. Does your child take a nap during the day?	☐	☐	
11. Does your child have trouble sleeping?	☐	☐	
12. Is your child potty trained?	☐	☐	
13. Can your child tell you if he/she has to go to the bathroom?	☐	☐	
14. Does your child wear a diaper or pull-up?	☐	☐	☐ Day time ☐ Night time ☐ Other _____
15. Can your child wash and dry own hands?	☐	☐	
16. Can your child dress and undress with little assistance?	☐	☐	
17. Can your child clean up after himself/herself with reminders/help?	☐	☐	
18. Does child have any difficulties expressing him/herself in words?	☐	☐	
19. Do others have trouble understanding your child?	☐	☐	
20. Have there been any big changes in your child's life in the past year? (i.e. death, divorce, move, change in parenting, new baby, etc.)	☐	☐	
22. How does child express anger/frustration?			
23. Special fears?	☐	☐	
24. Is a physician, dentist, therapist or other health professional treating your child for any problem or condition?	☐	☐	Please Specify: _____
25. How does your child act with you and others:			
Pregnancy/Birth History	**Yes**	**No**	**Explain "Yes" Answers**
26. Did child have any problems at birth?	☐	☐	
27. Did child stay in hospital for medical reasons longer than usual?	☐	☐	
Hospitalizations and Illnesses	**Yes**	**No**	**Explain "Yes" Answers**
28. Has child ever been hospitalized or operated on?	☐	☐	
29. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?	☐	☐	
30. Has child ever had a serious illness?	☐	☐	

Child's Name: _____

CHILD'S HEALTH RECORD

Health Problems(continued)	**Yes**	**No**	**Explain "Yes" Answers**
31. Does your child have any of these problems weekly or more often? ☐Vomiting ☐Diarrhea ☐Constipation ☐Chewing ☐Swallowing ☐Dental Pain	☐	☐	
32. Does child have difficulty seeing/vision problems? (Squint, cross eyes, looking closely at books)	☐	☐	
33. Is child wearing (or suppose to wear) glasses?	☐	☐	
34. Was last checkup more than a year ago?	☐	☐	
35. Has child had a convulsion or seizure?	☐	☐	If "yes" When did it last happen? _____ What medicine is child taking for seizure? _____
36. Febrile or Epilepsy?	☐	☐	
37. Is child taking medicine for seizures?	☐	☐	

38. Does your child have any of the following MEDICAL/PHYSICAL conditions?	**Yes**	**No**	**Age Last Occurred**	**Describe condition**	**Does this condition require special accommodation?**
a. ADHD/ADD/ODD	☐	☐			
b. Anemia	☐	☐			
c. Asthma/Respiratory problems	☐	☐			
d. Bowel/Bladder problems	☐	☐			
e. Bleeding tendencies	☐	☐			
f. Chickenpox	☐	☐			
g. Diabetes	☐	☐			
h. Ear Infections/hearing problems	☐	☐			
i. Eczema/skin problems	☐	☐			
j. Frequent nose bleeds	☐	☐			
k. German Measles	☐	☐			
l. Heart/blood vessel disease	☐	☐			
m. High Blood Lead Level results	☐	☐			
n. Heart problems	☐	☐			
o. Liver disease	☐	☐			
p. Measles	☐	☐			
q. Meningitis	☐	☐			
r. Mumps	☐	☐			
s. Pain in the teeth or gums	☐	☐			
t. Problems walking/climbing	☐	☐			
u. Rheumatic fever	☐	☐			
v. Scarlet Fever	☐	☐			
w. Sickle Cell disease	☐	☐			
x. Whooping Cough	☐	☐			
y. Other	☐	☐			

	Yes	**No**	
39. Does child have any allergy problems (Rash, hives, itching, swelling, difficulty breathing, sneezing)? ☐ a. When taking any medication? ☐ b. When near animals, furs, insect, dust, etc. ☐ c. Foods	☐ ☐ ☐	☐ ☐ ☐	If "yes" explain What medicine? _____ What things? _____ How does child react? _____
40. Do any of the conditions we've talked about so far get in the way of the child's everyday activities?	☐	☐	Describe how: _____
41. Did a doctor or other health professional tell you the child have this problem?	☐	☐	What doctor? _____ When? _____

MEDICATION CAN NOT BE GIVEN AT SCHOOL WITHOUT ALL REQUIRED WRITTEN DOCUMENTATION COMPLETED AND ON FILE.

_____ _____ _____

Print Name *Signature* *Date*