Form 3-44

Community Action Team
CHILD & FAMILY DEVELOPMENT PROGRAMS
Child Health History

Center: ______________________ Classroom: ☐AM 1 ☐AM 2 ☐PM 1 ☐PM 2 Date: ________________

Child's name: ___________________________________ Date of birth: _________________ Sex ___________

Hospitalizations And Illnesses	
Has your child ever been hospitalized (for prematurity or other) or operated on? If yes, explain:	☐ Yes ☐ No
Has your child ever had a serious illness (seizures for any reason, or other) or accident? If yes, explain:	☐ Yes ☐ No
Health	
Does your child have frequent: ☐ sore throat ☐ cough ☐ urinary infections or trouble urinating ☐ stomach pain ☐ vomiting ☐ diarrhea ☐ rashes or skin irritation Explain:	
Does your child have difficulty seeing (squint, cross-eyes, looks closely at books)? Does your child wear glasses? Date last seen by eye Doctor: _____________ If yes, explain:	☐ Yes ☐ No ☐ Yes ☐ No
Does your child have problems with ears/hearing (frequent earaches, infections, drainage, hearing loss)? If yes, explain:	☐ Yes ☐ No
Is your child currently being treated by a physician? If yes, explain:	☐ Yes ☐ No
Has your child had a physical (Well Child Exam) in the last 12 months?	☐ Yes ☐ No
Is your child currently being treated by a dentist? If yes, explain:	☐ Yes ☐ No
Has child had a dental exam in last 12 months?	☐ Yes ☐ No
Is your child taking medication at this time? If yes, explain:	☐ Yes ☐ No
Has your child been diagnosed or do you suspect, a chronic disease: ☐ asthma ☐ diabetes ☐ seizure disorder ☐ other, list: ___________________________ Explain:	
Child's allergies diagnosed by a health care provider to: ☐ dust ☐ plants ☐ Food ☐ other, list: ______________ Explain:	
If not, do you believe they have allergies? If yes, explain:	☐ Yes ☐ No
General Information	
Is your child potty trained?	☐ Yes ☐ No
Do you have any concerns about your child's health, development or behavior? If yes, explain:	☐ Yes ☐ No
Is your child being seen by a specialist? If yes, name of specialist: ________________________________	☐ Yes ☐ No
Does your family have any current health issues? If yes, explain:	☐ Yes ☐ No
Any major changes in past 12 months? If yes, explain:	☐ Yes ☐ No
Does your child have health insurance? Type: ☐ OHP ☐ Private: ___________ ☐ Other: _________ Do you or anyone in your family need assistance accessing health insurance? Explain:	☐ Yes ☐ No ☐ Yes ☐ No

___________________________________ ___________________________

Signature of Parent/Guardian Date

Updated 05/17