** HEAD START/EARLY HEAD START CHILD HEALTH HISTORY**

**MEDICAL HEALTH, NUTRITION, SOCIAL EMOTIONAL DEVELOPMENT**

**Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s doctor (Medical Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s dentist (Dental Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialist (who & why) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HEALTH**

**Does your child have any allergies? YES NO If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is your child being treated for any health condition? YES NO If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Please check if your child has or has had any of the following health conditions:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Asthma** |  | **Skin irritations, rashes** |
|  | **Eczema** |  | **Bladder, urinary tract problems or infections** |
|  | **Diabetes** |  | **Constipation, diarrhea, bowel, intestinal problems** |
|  | **Sickle Cell Disease** |  | **Frequent infections** |
|  | **Seizures** |  | **Frequent sore throat or cough** |
|  | **Anemia** |  | **ADD/ADHD (hyperactivity)** |
|  | **Epilepsy** |  | **Hepatitis** |
|  | **Heart, bleeding, blood disorders** |  | **Chickenpox** |

**Other condition or comments for any above answers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICATION**

**\*Any medication that needs to be taken at school must be in the original container with prescription label. Parent or guardian must sign the medication administration log.**

**Is your child prescribed any medication? YES NO Will medication need to be given at school? YES NO**

**If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**VISION: Does your child have difficulty seeing? (squint, cross eyes, look closely at books?) YES NO**

**Does your child wear, or is he or she supposed to wear glasses? YES NO**

**If so, date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of vision provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEARING: Does your child have problems with their ears? (pain, frequent earaches, draining, hearing loss, TUBES placed) YES NO If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like to discuss any health problems with the Health Coordinator? YES NO**

**NUTRITIONAL HEALTH**

**Are there any foods your child does not eat because of medical, religious or personal reasons? YES NO**

**If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any food allergies? YES NO If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\*Any food allergy will require an Allergy Action Plan filled out by the child’s doctor.**

**Does your child’s weight appear normal to you? YES NO**

**Do you have any concerns about your child’s growth, nutrition or eating? YES NO If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you know about the “My Plate” program? YES NO**

**Do you know about your child’s BMI (body mass index) ? YES NO**

**DENTAL HEALTH**

**Does your child see the dentist once a year? YES NO If so, last appointment date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does child brush his/her own teeth? YES NO Do you assist him/her with brushing? YES NO**

**Does anything appear abnormal with child’s teeth or gums? (swelling, redness, apparent decay, pain)**

**Any concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL/ EMOTIONAL HEALTH**

**What is one or two things your child is interested in or does especially well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Do you have any concerns about how your child expresses his/her emotions? YES NO If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**How does your child learn best? (circle) visual hands on verbal instruction other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child need help with the bathroom? YES NO How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child nap? YES NO Does he/she wear a pull-up when taking a nap? YES NO**

**Is your child comfortable around adults he/she doesn’t know? YES NO If not, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If your child gets upset, what is the best way to calm him/her down? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Does your child worry a lot, or is he/she very afraid of anything? YES NO If so, what things seem to cause him/her to worry or to be afraid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have there been any recent changes or problems in your child’s life that may affect their behavior? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there any information about your family’s culture or values that you would like us to share with your child’s teacher? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are there any pets in your home? YES NO**

**Has your child been diagnosed with a disability? YES NO Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have an IEP/ IFSP? YES NO**

**Has your child or any member of your family been diagnosed with a mental illness? YES NO If so, who and explain:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EARLY HEAD START ONLY**

**Were there any complications with the delivery of your child?**

**Gestational Diabetes \_\_\_\_\_\_ High blood pressure (preeclampsia) \_\_\_\_\_**

**High risk pregnancy \_\_\_\_\_\_\_**

**Additional comments or complications : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Were there any complications with delivery?**

**Premature rupture of membranes \_\_\_\_\_ Excessive bleeding \_\_\_\_\_\_**

**Forceps used \_\_\_\_\_\_ Fetal distress \_\_\_\_\_\_**

**Any additional comments or complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Did the baby stay in the hospital after mother went home? YES NO**

**Any additional newborn health issues when baby went home? YES NO If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**I HAVE ANSWERED THE QUESTIONS ABOVE TO THE BEST OF MY KNOWLEDGE:**

**Parent’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR OFFICE USE BELOW**

|  |  |  |  |
| --- | --- | --- | --- |
| **Annual Review** | **YES** | **NO** | **Notes** |
| **Any changes to child’s history**  **Date of review: \_\_\_\_\_\_\_\_\_\_**  **Staff signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Any changes to child’s history**  **Date of review: \_\_\_\_\_\_\_\_\_\_**  **Staff signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Any changes to child’s history**  **Date of review: \_\_\_\_\_\_\_\_\_\_\_**  **Staff signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |

**HEAD START/EARLY HEAD START HISTORIA DE NIÑO SALUD**

**MEDICO SALUD, NUTRICION, SOCIALES EMOCIONALES DESARROLLO**

**Nombre de hijo(a)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Genero\_\_\_\_\_\_Nacimiento\_\_\_\_\_\_\_\_\_**

**Doctor (Medico Primero) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dentista (Dentista Primero) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Especialista (quien y por qué) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ seguro \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SEGURO MEDICO**

**¿SU HIJO TIENE ALGUNA ALERGIA? Sí NO Si sí, explica: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Es el niño que está siendo tratada por cualquier situación actual? Sí NO Si sí, explica: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Por favor marca si tu hijo(a) tiene o tenía siguiente condiciones salud:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Asma** |  | **Irritaciones de la piel, erupciones** |
|  | **Eczema** |  | **Vejiga, problemas del tracto urinario o infecciones** |
|  | **Diabetes** |  | **Problema intestinal, intestinal, estreñimiento, diarrea** |
|  | **enfermedad de células falciformes** |  | **Infecciones frecuentes** |
|  | **Convulsiones** |  | **Frecuente dolor de garganta o tos** |
|  | **Anemia** |  | **ADD/ADHD (hiperactividad)** |
|  | **Epilepsia** |  | **Hepatitis** |
|  | **Corazón, hemorragia, desordenes de la sangre** |  | **Varicela** |

**Otro condición o comentario para respuestas anteriores: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medicación**

**\*** **Cualquier medicamento que debe ser tomado en la escuela debe estar en su envase original con la etiqueta de la receta. Padre o tutor debe firmar el registro de la administración de medicación.**

**¿Es su hijo recetado algún medicamento? Si NO ¿Medicamento tendrá que darse en la escuela? SI NO**

**If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**VISION: Su hijo(a) tiene dificultad para ver? (entrecerrar los ojos, cruzar los ojos, mira atentamente en los libros)? SI NO**

**¿Su hijo(a) usa gafas? SI NO**

**Si sí, fecha de ultima examen: \_\_\_\_\_\_\_\_\_\_\_\_ Nombre de doctor para visión: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Oídos: ¿Su hijo(a) tiene problemas con sus oídos? (dolor, frecuentes dolores de oídos, drenaje, perdida de la audición, tubos colocados) SI NO ¿Sí?, explica\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Te gustaría discutir cualquier problema de salud con la coordinadora de salud? SI NO**

**SALUD NUTRICIONAL**

**¿Tu hijo(a) tiene alergias porque de comida, médico, religioso, o razones personales? SI NO**

**¿Sí, explica: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Tiene alergia de comida? SI NO ¿Sí?, por favor lista: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\*Cualquier alergia alimentaria requerirá un plan de acción de alergia llenado por el doctor del hijo(a).**

**¿Peso de tu hijo(a) parece normal? SI NO**

**Tienes preguntas sobre tu hijo(a) nutrición, comiendo, o crecimiento del hijos? SI NO ¿Sí?, explica \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**¿Sabes sobre el “My Plate” programa? SI NO**

**¿Sabes sobre índice de masa corporal de tu hijo(a)? SI NO**

**SALUD DENTAL**

**¿Se visita dentista cada año? SI NO Si sí, fecha de última cita \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Puede niño cepillo su/sus dientes? SI NO ¿Haga le ayuda ella/ el con el cepillado? SI NO**

**¿Nada parece anormal con los dientes o las encías del niño? (inflamación, enrojecimiento, evidente decaimiento, dolor) Cualquier preguntas:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SALUD SOCIAL/ EMOCIONAL**

**¿Qué es una o dos cosas, su hijo le interesa o lo hace especialmente bien? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**¿Tiene alguna preocupación sobre como su niño expresa emociones? SI NO Sí?, explica \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Cuál es la mejor manera para su hijo/a aprender? (marca un) visual manos en instrucción verbal otro\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Tu hijo(a) necesita ayudar cuando usando al baño? SI NO Cómo?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Toma una siesta? SI NO Usa un pull-up cuando se toma una siesta? SI NO**

**¿Es su hijo(a) incomodo alrededor de adultos desconocidos? YES NO Si no, explica: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Si su hijo(a) se enfada, cual es la mejor manera se la calme? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**¿Su hijo(a) preocupa mucho, o es mucho miedo de nada? SI NO Si es así, que cosas parecen causar le preocuparse o tener miedo? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Ha habido cambios recientes o problemas en la vida de su hijo(a) pueda afectar su comportamiento? Si es así, por favor explica: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Tienes información sobre tu cultura de familia que quieres compartir con la maestra de hijo/a? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**¿Tienes animales o mascotas a la casa? SI NO**

**¿Diagnosticada con discapacidad? SI NO EXPLICA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tiene IEP/ IFSP? Terapista/Especialista SI NO**

**¿Su hijo(a) o algún miembro de su familia han diagnosticado con una enfermedad mental? SI NO Si es así, quien y explica:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EARLY HEAD START ONLY**

**¿Complicaciones con Embarazo?**

**Diabetes gestacional \_\_\_\_\_\_ Alta Presión (preclamsia) \_\_\_\_\_**

**Regisco potencial Embarazo?\_\_\_\_\_\_\_**

**Adicional comentarios o complicaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**¿Complicaciones con en sala de parto?**

**Prematuro ruptura de membranas \_\_\_\_\_ mucho sangrando \_\_\_\_\_\_**

**Fórceps uso \_\_\_\_\_\_ bebe está sufriendo mucho \_\_\_\_\_\_**

**Adicional comentarios o complicaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**¿Bebe todavía está en la hospital después de nació? Después de Mama salida de la hospital? SI NO**

**En los primeros días al casa de nacimiento, bebe tiene problemas con salud? SI NO If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yo tengo contestó a lo mejor de mi conocimiento:**

**Firmar de Padres: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Personal Firmar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR OFFICE USE BELOW**

|  |  |  |  |
| --- | --- | --- | --- |
| **Annual Review** | **YES** | **NO** | **Notes** |
| **Any changes to child’s history**  **Date of review: \_\_\_\_\_\_\_\_\_\_**  **Staff signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Any changes to child’s history**  **Date of review: \_\_\_\_\_\_\_\_\_\_**  **Staff signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| **Any changes to child’s history**  **Date of review: \_\_\_\_\_\_\_\_\_\_\_**  **Staff signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |