

Child's Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate:	Today's Date:
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Child's Health History

Name of Doctor/Clinic:	City/State:	Phone number:
Were there any significant problems during pregnancy or birth? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please explain:		
Has your child had surgery or been hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes, Please explain:		
Date last seen by a healthcare provider(for reasons other than immunizations):		

Medication

Does your child take medication on a regular basis? <input type="checkbox"/> No <input type="checkbox"/> Yes, Reason:

Name of medication(s), dosage and when taken:

Has your child had any of the following?	Age of child or date of incident ▼	
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Other breathing problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Seizures or other neurological problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Heart or other cardiovascular problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Bladder or urinary tract problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Bowel or other GI problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Bone or joint problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Eczema or skin problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Frequent ear infections or tubes	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Other ear, nose or throat problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Tuberculosis exposure	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Chicken Pox or vaccination for such	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Diabetes or other endocrine problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Injury or abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Car sickness	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:

Other describe:

Nutrition History

Is there any food or drink that your child should not eat for cultural, religious, personal reasons or medical reasons **other than allergies**? (Note: use the allergy chart on the next page to list any allergies to food or drink)

Yes, list below

No, skip to next question

Name or food/drink:	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
	<input type="checkbox"/> Cultural	<input type="checkbox"/> Religious	<input type="checkbox"/> Personal	<input type="checkbox"/> Medical/describe:
Does your child have any problems with chewing or swallowing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:		
Check the box if you have concerns about your child's:	<input type="checkbox"/> Eating habits	<input type="checkbox"/> Height	<input type="checkbox"/> Weight	
Please describe:				

Allergy History

Does your child have allergies or reactions (including intolerances) to food, medicine, insects, animals or other substances?

Yes, please complete chart below

No – Skip to Dental History

Allergy Chart Note: If your child has a food or milk allergy, we must have written documentation of the allergy from the doctor. For milk allergies, the doctor must also name a substitute for the milk.

Do you keep epinephrine (epi-pen) available at home for your child's allergy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
List each allergy or food separately	Briefly describe child's reaction and/or check symptoms			Potential Severe Reaction*	Doctor/Date of Diagnosis	
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Hives	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	

*** If the allergy has the potential to be severe, the child's health care provider should complete a medical statement and an allergy care plan should be completed.**

Additional information about allergy:

Dental History

Name of dentist:	Date last seen by dentist:	City/State:	Phone number:
How would you rate your child's dental health?	<input type="checkbox"/> Very good	<input type="checkbox"/> Somewhat good	<input type="checkbox"/> Fair <input type="checkbox"/> Somewhat bad <input type="checkbox"/> Very bad
Has your child ever had an injury to the teeth or gums?	<input type="checkbox"/>	<input type="checkbox"/> Yes, please explain:	
Has your child complained about pain in the teeth or gums?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Is there fluoride in the water at your home, or is your child taking a prescribed fluoride supplement?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Parental Concerns

Do you have any concerns about your child's vision?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's hearing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's speech?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's behavior?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any concerns about your child's development?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:
Do you have any other concerns about your child?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, Please describe:

Additional information regarding concerns:

Communicable Disease Outreach Program