CASI Head Start Child (3-5) Health History 2021-2022

Student Name: _____ **Date of Birth: _____**

Doctor's Name: _____ **Doctor's Phone Number: _____**

Dentist's Name: _____ **Dentist's Phone Number: _____**

****Does your child have health insurance? ☐ Yes ☐ No**

****If Yes, What type of insurance? (Please Circle) HHW/Med # _____ Private Other:_____**

☐ NO MEDICAL HISTORY ☐ NO KNOWN ALLERGIES

Health Conditions (Check all that apply)

- ☐ **ADD/ADHD** Meds:_____
- ☐ **Allergies:** ☐ Food: _____ ☐ Meds: _____ ☐Bee/Insect Stings ☐ Other: _____
  Epipen? ☐ Yes ☐ No
- ☐ **Asthma/Reactive Airway** ☐ Inhaler ☐ Nebulizer Date Last Used (Month/Year): _____
  Will Inhaler/Nebulizer be used at school? ☐ Yes ☐ No
- ☐ **Behavioral/Emotional/Psychological Concerns** Medication: _____
- ☐ **Blood Disorder** ☐ Anemia ☐ Sickle Cell ☐ Hemophilia ☐ High Lead
- ☐ **Seizure Disorder:** List Type: _____ **Date of Last Seizure (Month/Year):** _____
  Describe Seizure Activity: _____
  Medication: _____ **Diastat Required? ☐ Yes ☐ No**
- ☐ **Diabetes ☐ Heart Condition ☐ High Blood Pressure ☐ Murmur ☐ Other:** _____
- ☐ **Hearing ☐ Tubes ☐Hearing Impaired ☐ Hearing Aids ☐ Other:** _____
- ☐ **Vision ☐ Glasses ☐ Vision Impaired ☐ Lazy Eye ☐ Other:** _____
- ☐ **Has your child ever been hospitalized? ☐ Yes ☐ No If yes, Why? and When?** _____
- ☐ **List any routine medications your child takes:** _____

Wears pull-ups/diapers at school? ☐ Yes ☐ No
Do any person(s) providing care for your child smoke? ☐ Yes ☐ No

****Does your child currently have an IEP/IFSP? ☐ Yes ☐ No If yes, what school district?** _____

****Is your child receiving counseling services? ☐ Yes ☐ No If yes, Where?** _____

****List any other medical conditions that Head Start needs to be aware of:** _____

Has your child previously been in a: (PLEASE CIRCLE) HEAD START DAYCARE CHURCH OTHER NO

How was the experience? _____

DOES YOU CHILD NAP? YES _____ NO _____ COMMENT_____

Developmental History

At what age did your child do the following: Sit Up without Help: _____ Crawl: _____ Talk: _____

Understand things being said to him/her: _____ Follow Simple Directions: _____

****Do you feel like your child has any delays? ☐ Yes ☐ No If yes, please list:**_____