**Rock-Walworth Comprehensive Family Services, Inc.**

Head Start and Early Head Start

1221 Henry Avenue, Beloit WI 53511 **Phone:** (608) 299-1500 or 1-800-774-7778 **Fax:** (608) 299-1629

**Health History, Oral Health and Nutrition History/Screening**

**Complete front and back: CC: \_\_\_\_\_\_\_\_\_**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please be advised that Individual Service plans will be developed for your child in response to any health concerns you share and that need special attention (examples: asthma, allergies, seizures etc.)**

Does your child have allergies (food, medication, environment, latex, etc)? □ Yes □ No

If yes, please describe all allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe allergy reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did mother have any health problems during pregnancy or delivery? □ Yes □ No

 Was child born more than 3 weeks early or late? □ Yes □ No

 Were there any concerns with child at birth or in nursery? □ Yes □ No

 What was child’s birth weight? \_\_\_\_\_\_\_\_\_\_\_**lbs.** \_\_\_\_\_\_\_\_\_\_\_\_**oz.**

 **Explain “yes” answers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Has child ever been hospitalized or had surgery? □ Yes □ No

 Has child ever had a serious accident or injury? □ Yes □ No

 Has child ever had a serious illness? □ Yes □ No

 **Explain “yes” answers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. **Does your child have, or has your child had … History of:** **Currently:**

 Asthma □ Yes □ No □ Yes □ No

 Disabilities (physical/ sensory/thinking abilities)? □ Yes □ No □ Yes □ No

 Diabetes? □ Yes □ No □ Yes □ No

 Heart Problems? □ Yes □ No □ Yes □ No

 MRSA? □ Yes □ No □ Yes □ No

 Seizures? □ Yes □ No □ Yes □ No

 Sickle Cell Disease □ Yes □ No □ Yes □ No

 Sickle Cell Trait □ Yes □ No □ Yes □ No

 High Lead Level/Lead Poisoning □ Yes □ No □ Yes □ No

 Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Yes □ No □ Yes □ No

 **Explain “yes” answers** (**include name(s) of any medications**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any **EMERGENCY** medical conditions we should know about before your child actually rides a bus or attends class? □ Yes □ No, If he or she does, **what is this condition?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Is child taking daily medications? □ Yes □ No

 Is the medication for a medical diagnosis? □ Yes □ No

 Will medication need to take be given while at Head Start/Early Head Start? □ Yes □ No

 **Explain “yes” answers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Does child have any vision/eye problems? □ Yes □ No Does child wear (or should wear) glasses? □ Yes □ No

6. Does child have hearing/ear problems? □ Yes □ No

 Does child currently have tubes in his/her ears? □ Yes □ No Surgery Date/Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Health Care Coverage: **(please check √)** □ Private Insurance □ No Medical Coverage □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Badger Care/MA:** **Badger Care card 10-digit number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Oral Health**

□Yes □No Do you need help finding a dentist to get a Head Start exam for your child?

□Yes □No Does your child drink fluoridated water?

□Yes □No How many times does your child brush his/her teeth per day? **(Circle)** 0 1 2 More

□Yes □No Does your child get help when brushing his/her teeth?

□Yes □No Does your child snack during the day?

□Yes □No Does your child drink from a bottle?

□Yes □ No Does your child walk around with a bottle or sippy cup (other than at meal times)?

□Yes □No Does your child take a bottle or sippy cup to bed?

□Yes □No Has your child seen a dentist yet?

□Yes □No Has your child ever had a bad experience at the dentist?

□Yes □No Has your child had cavities?

□Yes □No Does your child complain about mouth pain?

**NUTRITION**

1**. Does your child feed him or herself: □ Yes □ No Does your child need assistance with eating: □ Yes □ No**

2.  **How many servings does your child eat from the following food groups each day?**

|  |  |  |  |
| --- | --- | --- | --- |
|  **Food Group**  | **No** | **Yes** |  **If yes, # of servings** |
| Milk, Yogurt & Cheese Group |  |  |  |
| Vegetable Group |  |  |  |
| Fruit Group |  |  |  |
| Meat, Poultry, Fish, Dry Beans, Eggs & Nuts Group |  |  |  |
| Bread, Cereal, Rice and Pasta Group |  |  |  |
| Fats, Oils and Sweets |  |  |  |
| Water |  |  |  |
| My child’s favorite food is: |

3. When does your child eat the most? □ Breakfast □ Lunch □ Supper □ Snacks □ Eats equally at each opportunity

4. **Does your child have any dietary restrictions?** □ Yes □ No Explain briefly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. **Do you feel your child’s eating habits are a problem?**  □ Yes □ No

 Are you concerned your child is not eating enough? □ Yes □ No

 Are you concerned your child is eating too much? □ Yes □ No

Are you concerned about the type of food your child eats? □ Yes □ No

 Are you concerned about when your child eats? □ Yes □ No

 Has your child’s appetite changed recently? □ Yes □ No If yes, increase \_\_\_ or decrease \_\_\_\_

 Does your child chew on things that are **NOT** food? □ Yes □ No

If yes, on what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. **Are you concerned about your child’s weight?**  □ Yes □ No

 Are you concerned your child is over weight? □ Yes □ No

 Are you concerned your child is underweight? □ Yes □ No

7. **How does your child feel about meal time?** Enjoys meals \_\_\_ Not interested \_\_\_ Needs encouragement \_\_\_

8. **Does your child have any of these problems weekly or more often?**

 Vomiting \_\_\_\_ Diarrhea \_\_\_\_ Constipation \_\_\_ Difficulties chewing \_\_\_\_ Difficulties swallowing \_\_\_\_

9**. Is your child physically active for 60 minutes or more?** Daily \_\_\_\_ 2-3 days per week \_\_\_\_ Rarely \_\_\_\_

10. **How many times per day does you child usually eat?** 1-2 \_\_\_\_\_ 2-4 \_\_\_\_\_ 4-6 \_\_\_\_\_ 6+ \_\_\_\_\_

11. **Are you interested in learning more about nutrition for your family?** □ Yes □ No

 By receiving written material? □ Yes □ No

 By talking with a registered dietician? □ Yes □ No

 12. **Would you like to receive information about food, nutrition, budgeting or parenting education programs through**

 **the University Extension?** □ Yes □ No

 If so, may we share your name, address and telephone number with this program? □ Yes □ No

13. **If you are not receiving WIC services, are you interested in receiving services or information about WIC?**  □ Yes □ No

 If you are interested in receiving information or in signing up for WIC services, may we share your name, address

and phone number/s with WIC staff? □ Yes □ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature Date:**

**(1/11)**