|  |  |  |
| --- | --- | --- |
| **Childs Name *(First, Middle, Last)*** | **Sex:** F ❑ M ❑ | **Birthdate:**  |
| **Child’s Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Visit: \_\_\_\_\_\_\_\_\_\_\_** **Child’s Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_\_** | **Health Insurance Medical & Dental:***(check one)*❑ **Medicaid** ❑ **Private**❑  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Please circle if your child has any of the following:**

 Allergy\*

 Allergy to food\*

 Anemia

 Asthma\*

 Bowel/Bladder problems

 Diabetes\*

 Frequent earaches/Infections

Frequent nose bleeds

Hearing problems/Wears hearing aid

Heart condition\*

High lead level

Lactose Intolerance

Reactive Airway Disease (R.A.D)\*

Second hand smoke exposure

 Seizure disorders\*

 Serious Illness/Injury

 Surgery/Hospitalizations

 Vision Problems/Wears Glasses

 Wheezing\*

 Other Serious Disorders

 Please explain anything circled above:

 Do you have concerns about your child’s overall health or development?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **MEDICATION**  | **COMMENTS/EXPLAIN** |
|  |  | Does your child take medication?  |  |
|  |  | Will your child need to take medication while in our care? (Yes indicates a need for a ***Medication Form***) |  |
|  |  | Does your child use any form of emergency medication?Ex. Epi-pen, inhaler… |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **ORAL HEALTH ASSESSMENT** | **COMMENTS/EXPLAIN** |
|  |  | Has your child seen a dentist?  |  |
|  |  | Has your child ever had a cavity?  |  |
|  |  | Does your child complain of mouth pain?  |  |
|  |  | Do you help your child brush his/her teeth? |  |

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Year Review Date |

**FOR OFFICE USE ONLY:**

 Additional documents required before a child can start: ❑ Physical Records ❑ Physician Records

❑ Individual Health Plan ❑ Medication Form ❑ Dietary Restriction Request ❑ Allergy Restriction Request

❑ Allergy Action Plan ❑ Asthma Action Plan ❑ Seizure Plan ❑ Toileting ISP ❑ None

 Rev: 3/24 MG