Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

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HEALTH HISTORY/NUTRITION ASSESSMENT

Child's Name:	Date of Birth:
Parent/Guardian:	Parent/Guardian Phone #:
Homebased Center/FCCH:	Teacher/Provider:

1) Medical History

1. **How much did your child weigh at birth?**_____ lbs. _____ oz.

Yes / No 2. **Has anyone in your family ever had any serious illnesses or medical conditions** (i.e. heart disease, cancer, tuberculosis, asthma, mental illness, substance abuse, etc.)? *If yes, please explain?* _____

Yes / No 3. **Were there any problems with your child immediately after birth?** *If yes, please explain*:_____

Yes / No 4. **Is your child taking any medication every day?** *If yes, please explain*: _____

Yes / No 5. **Will medication be needed at school?** *If yes, please explain*: _____

Yes / No 6. **Has your child ever been prescribed an EPI-PEN?** *If yes, please indicate allergy*: _____

Yes / No 7. **Are there any conditions requiring special attention at childcare setting/school?** *If yes, please explain:* _____

Yes / No 8. **Is your child allergic to any of the following? (Please check)** Animals☐ Perfume☐ Trees☐ Birds☐ Pollen ☐ Grass☐ Flowers☐ Dust☐ Trees☐ Smoke☐ Weather Changes ☐ Other: _____

Yes / No 9. **Does anyone in the household smoke?**(Where? e.g. at home?)_____

2) Has your child ever had the following illnesses?

	Yes		Yes		Yes
Measles		Ear/Nose/Throat Problems		Eye Problems	
Mumps		Urinary/Kidney Problems		Heart Disease	
Chickenpox		Muscle/Bone Problems		Pneumonia	
Scarlet Fever		Anemia		Intestinal Problems	
Respiratory Problems		Blood Pressure Problems		Diabetes	
Tuberculosis		Rheumatic Fever		Other	
Seizures		Bee Sting Allergy		**None of the Above**	

If you answered **yes to any illness**, please explain **(triggers, medications needed during program hours, how long ago, how often, etc.):** _____

_____

_____

Mandatory
Revised 1/17
CF/H-3a

3) Has your child ever had the following? If yes, please check the box and give date, and explain to the best of your knowledge.

Yes		Date	Comments
	Hospitalizations		
	Operations		
	Serious Injuries		
	Other Health Problems/Illnesses		
	Allergies to Medications (i.e., penicillin, sulfa, drugs)		

4) Developmental History (Staff: Do not enter in COPA)

5) * Immunization History (Staff to complete after final review and input of child immunizations)

6) Dental Information

* Yes / No **Does your child have dental insurance? Name of Insurance**: _____

* Yes / No **Does your child have an ongoing source of continuous and accessible dental care/dentist (Do you have a family dentist)?**
Dentist Name: _____ Address: _____

* Yes / No **Does your child have dental problems now?** _____

7) Nutrition Screening

Yes / No 1. **Does your child eat a variety of foods, including fruits and vegetables?**

Yes / No 2. **Does your child drink from a baby bottle now?**

Yes / No 3. **Do you have any concerns about your child's growth, nutrition or eating (eats too much or too little, picky eater, diarrhea, constipation)?** *If yes, please explain*: _____

_____

_____

_____

8) Food Substitution

1. **Is your child restricted from foods due to religious, medical, or personal reasons?** ☐ Yes ☐ No
   If yes, please explain (What foods, type, restrictions): _____
   _____
2. **Does your child have any food allergies or intolerances?** ☐ Yes ☐ No
   If yes, please explain: _____
3. **What kind of reaction does your child have when your child eats the food specified in Question #2?**
   ☐ **Rash** ☐ **Swelling** ☐ **Diarrhea** ☐ **Difficulty breathing** ☐ **Life threatening** ☐ **Other**
4. **Is your child on any special diet prescribed by a doctor?** ☐ Yes ☐ No
   If yes, please explain: _____
   _____
   _____

9) *Lead Poisoning Screening on last page.

10) Asthma

* Yes / No 1. **Has your child ever been diagnosed by a medical professional as having asthma?**
(*if your answer is NO, please SKIP to #11)

a) Date of diagnosis: _____

b) How many episodes per year? _____

c) Is it seasonal? At what time of year do the episodes most often occur? _____

_____

d) Is it well controlled? How? _____

_____

e) Asthma triggers? _____

Yes / No 2. **Has your child experienced any of the following due to ASTHMA? If YES,** please check.

☐ Treatment in the ER, number of times: _____

☐ Hospitalizations, number of times: _____

Yes / No 3. **Have you ever given your child any medications for asthma?**
If yes, please check all that your child has used in the last two years.

☐ **Albuterol**	☐ **Intal**	☐ **Ventolin**	☐ **Pedia Pred**
☐ **Tedral**	☐ **Prelone**	☐ **Proventil**	☐ **Primatine Mist**
☐ **Marax**	☐ **Quiboron**	☐ **Other:** _____	

Yes / No 4. **Does your child use a Nebulizer or Inhaler?** If yes, how often? _____

11) Medical Coverage

* Yes / No 1. **Does your child have a family doctor? (Does your child receive medical services through ongoing source of continuous, accessible Medical care?)**
If yes, please answer the following:

Doctor's Name: _____

Address: _____

Phone Number: _____

(Staff: Please indicate "no" for County Health Department question in COPA)

* Yes / No 2. **Does your child have "regular" Medi-Cal (Blue Cross/Health Net/Central CA Alliance for Health)?**

* Yes / No 3. **Does your child have "emergency only" Medi-Cal?**

* Yes / No 4. **Does your child have private health insurance?**

Name of Insurance: _____

* Yes / No 5. **Does your child have any health insurance other than those listed above, such as Military Health, Tri-Care or Champus?**
Specify: _____

12) Tuberculosis Risk Assessment

Yes / No 1. **Was your child born in a high risk region (including Africa, Asia, Eastern Europe, Middle East, or Latin America)**

Yes / No 2. **Has your child ever traveled to a country with a high TB rate (for more than one month)?**

Yes/ No 3. **Has a family member, or someone your child has been in close contact with, had a positive TB test or received medications for TB (after a TB clearance has been completed)? If yes:**

What country did you travel to? _____ What year? _____ How long? _____

Yes/ No 4. **Does your child display one or more signs and symptoms of TB such as prolonged cough, coughing up blood, fever, night sweats, weight loss, and excessive fatigue?**

Yes/ No 5. **Is your child a current or former resident in a homeless shelter or live with someone who has been in jail or prison in the last five years?**

Certificate of Completion **(To be completed by nurse/health care provider)**

- ☐ **Child has no TB symptoms, none of the above or risk factors for TB and does not require further testing.**
- ☐ **Child has a risk factor, but has been evaluated for TB by medical provider who has provided clearance.**
- ☐ **Child has TB risk factors, and requires a Tuberculin Skin Test (TST/Mantoux/PPD).**

Nurse/Health Care Provider Signature:_____**Date:** _____

13) Lead Risk Assessment

Yes/No 1. **Was your home built before 1978? If so, do you see walls, furniture, or window sills in your home with chipping or peeling paint?**

Yes/No 2. **Has your child or anyone in your household been treated or monitored for lead poisoning greater>10?**

Yes/No 3. **Does your job/hobby involve lead exposure (painting, construction worker, auto radiator mechanic)?**

Yes/No 4. **Do you eat/drink, store or cook food in imported pottery that contains lead?**

Yes/No 5. **Does your child eat items such as lead contaminated soil, paint chips, candy (from other countries)?**

Notes regarding answers (how long ago, circumstances, exposure):_____

_____

Certificate of Completion **(To be completed by designated health staff)**

- ☐ Child has no risk factors for Lead Poisoning.
- ☐ Child has risk factors and a referral is being made to health care provider.
- ☐ Child has had a Lead Blood Test and is less than <5, no other concerns at this time.

Designated Health Staff Signature: _____ **Date:**_____

PARENT

SIGNATURE:_____**DATE:**_____

Designated Staff Only:

Health History Reviewed by (Staff Name):_____***Title:***_____ ***Date:***_____

Health History Reviewed by Designated Health Staff :_____***Title:***_____***Date:***_____

Information/Handouts or Forms Given/Follow-Up &Notes:_____

_____

Received by: _____ **Date:** _____

(Initials)