

Tri-County Head Start/Early Head Start

Child's Health Record

Child's Name _____

Is your child on WIC? Yes No County _____

Does your child have a regular Doctor? Yes No Name _____

Does your child have a regular Dentist? Yes No Name _____

Has your child had a Lead Test? Yes No Provider _____

Does your child currently have any diagnosed disabilities? Yes No If yes, please explain.

Diagnosed when/by whom? _____

Does your child have an Individualized Education Plan/IFSP? Yes No

Referral Agency _____

Health Concerns	Yes	No	Explain
Has your child had a serious and/or long-term illness?			
Does your child have difficulty seeing and/or wear glasses?			
Does your child have problems with hearing?			
Is your child potty trained? If no, what size diaper/pull ups?			
Is a specific brand used? If so, which one?			
Has your child ever had a convulsion or seizure?			If yes, when did it last happen?
Is your child taking medication for seizures?			If yes, what medicine?
Is your child now being treated by a physician and/or dentist for anything other than routine visits?			Physician/Dentist Name
Are there any conditions we have not talked that get in the way of your child's everyday activities?			
Did a doctor tell you the child had this problem?			
Does your child receive mental health treatment?			
Does your child have any allergies to food, medication or environment? Please explain.			
Will emergency medication be needed on site?			Name of medication:

*Please note that if your child needs medication during the school day, **we must** have a current medication authorization form on file, and a doctor's written orders.*

Does your child have an up-to-date shot record? ___ No ___ Yes, Date: _____

Does your child have an up-to-date physical? ___ No ___ Yes, Date: _____

Parent/Guardian Signature

Staff Signature

(For staff use only)

Is follow-up required? Yes, (health care plan in file)

No