COMMUNITY CHILD CARE CENTER
530 NW Greyhound Way Pullman, WA. 99163 (509) 334-9290
Head Start/EHS/ECEAP/Child Care

CCCC Health History Form (1-5 years)

Child's Name (Last, First, Middle)	Sex	Birth Date (MM/DD/YY)	Country of Birth

Health History

Name of child's Health Care Provider			
Name of child's Dentist			
		Child's Weight at Birth: Pounds_____ Ounces_____ Grams_____	
		Type of Delivery:	
Yes	No	Please Answer the Following:	
		Were you told your child was born early or premature? How Early?	
		Were drugs, alcohol or cigarettes part of family life during pregnancy?	
Does your child have any of the following?			
Yes	No	Health Concerns	If yes, Describe:
		1. Anemia	
		2. Breathing Problems* (Asthma, RSV, RAD, other) Must answer the question on the right. Do not leave blank.	When was the last time your child had to use medication for the breathing problem? _____ Has your child been hospitalized overnight two or more times in the past year for breathing problems? ☐Yes ☐No Has your child been seen in the emergency room three or more times in the past year for breathing problems? ☐Yes ☐No Comments:
		3. Bowel/bladder problems	
		4. Diabetes*	
		5. Frequent ear aches or infections	
		6. Hearing Concerns	
		7. Heart Conditions*	
		8. Frequent nose bleeds	
		9. Seizures*	

Child Health Plan Required/Potentially life-threatening condition

Yes	No	Health Concern	Is Yes, Describe:
		10. Skin condition	Is medication or lotion applied at home?? ☐Yes ☐No Are there things to avoid (e.g. certain soaps, grass, water play)? ☐Yes ☐No Comments:
		11. Tuberculosis Exposure	
		12. Walking/climbing difficulties	
		13. Vision concerns/wears glasses	
		14. Secondhand smoke exposure	
		15. Lead Exposure a. Lived in a house with peeling paint built before 1978? b. Has a sibling/relative or close friend with lead poisoning? c. Lives with an adult whose job or hobby involves lead? (i.e. welding, stained glass or pottery) d. Lived near a smelter/battery plant/car repair shop or other lead related industry? e. Have you or your family used home remedies such as azareon, greta, kohl, or pavlooah? (Circle all that apply).	
		16. Has your child ever been tested for lead?	
		17. Other health concerns? (Please List)	
		18. Has your child experienced any of the following? Chicken Pox, Measles, Mumps, Whooping Cough, other? Please describe.	
		19. Has your child experienced any serious illness/injury, surgery, or seen a specialist? If yes, when and for what?	
		20. Is tobacco currently in use in your home (i.e. smokeless tobacco, cigars, pipe, cigarettes?	
		21. Are drugs or alcohol currently in use in your home? If yes, what does this look like?	
		22. Has your child been exposed to violence in the home?	
Time (Hours)		23. How much time does your child spend being physically active each day? (running, jumping, dancing, etc.)	
Time (Hours)		24. How much time does your child spend each day watching TV/videos, playing computer/gaming systems, on tablet?	
		25. When riding in a car/truck, does your child use a car seat/booster?	
		26. When your child rides a bike/trike, does he/she wear a helmet?	

Child's Name:

Non-Food Allergies

27. Does your child have allergies or severe reactions to any of the following: ☐Yes ☐No If yes, please check only those that apply: ☐**Insect Bites/bee stings*** ☐Animals ☐Pollens/Hay Fever ☐Medications ☐Other (Please Specify)
Please describe your child's allergic reaction:
How do you treat your child's allergy?
Has the allergy been diagnosed by a doctor? ☐Yes ☐No
Child Health Plan Required/Potentially life-threatening condition

Medications

Yes	No	Please answer the following:
		28. Does your child take any medications? Please list ALL medications:
		29. Will your child need to take any medications during scheduled programming? (Staff: Please review Medication Administration Procedure; additional action required)

Dental

Yes	No	
		30. Has your child complained about pain in the teeth or gums? If yes, please describe:
		31. Does your child use fluoride toothpaste at home?
		32. How many times per day does your child brush teeth at home?
		33. Does your child go to bed with a bottle or sippy cup? If yes, what is in the sippy cup? (Staff: provide some education about sitting sugars and tooth decay)
		34. Has your child visited the dentist?

Nutritional Information

Yes	No	Please answer the following:
		35. Is your child receiving services through WIC?
		36. Does your family receive benefits through the SNAP program?
		37. Do you have questions about feeding your child? If yes, Please explain:
		38. Do you have concerns about what your child eats? How many meals _____ and snacks _____ are offered? Please explain:
		39. Do you share meals together as a family? If no, where does your child eat in the home? _____
		40. Does your child drink from a cup?
		41. Does your child drink from a baby bottle?
		42. Do you have any concerns about your child's growth? Please explain:
		43. Do you have any concerns about your child's weight? Please explain:
		44. Does your child take a prescribed iron supplement? Why? How often? Please explain:
		45. Does your child currently use any nutritional supplements (Pediasure, ensure, multivitamins, herbs, etc.)? If yes, which ones, how often, and for what reason:
		46. Does your child eat any nonfood items? (Example: crayons, marbles, paper, etc.). Please list: _____
		47. How would you describe your child's appetite?
		48. Does your child need assistance with feeding self?

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following:
		49. Has a medical provider ever told you that your child has a food allergy or intolerance? If yes, please explain: Does your child have an Epi-Pen? **Is this a life-threatening food allergy?***

Child's Name:		
		50. Are there foods that your child cannot eat for cultural/religious reasons? If yes, please list:
If your child has a food allergy or intolerance that has been diagnosed by a doctor, we will ask for documentation from your medical provider that includes a list of foods that can be substituted.		
****Child Health Plan Required/Potentially life-threatening condition***		

List Health and Nutritional Education Resources Shared with Parents

☐ Lead Information

☐ Nutritional Information

☐ Fluoride Information

☐ Other (please list):
(i.e. tobacco cessation, helmet, car seat, safety, other)

Signatures – First Year

Parent:	Date
Staff who reviewed with Parent	Date reviewed with parent
Interpreter (if applicable)	Date:

Signatures – Second Year

Parent:	Date
Staff who reviewed with Parent	Date reviewed with parent
Interpreter (if applicable)	Date: