COMMUNITY CHILD CARE CENTER

530 NW Greyhound Way Pullman WA, 99163

Head Start/EHS/ECEAP

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 earaches 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	If 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 ☐Pavlooah	
☐	☐	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 currently in use in your home?	
☐	☐	22. Is alcohol currently used in your home? If yes, what does this look like?	
☐	☐	23. Has your child been exposed to violence in the home?	
Time {Hours)		24. How much time does your child spend being physically active each day? (running, jumping, dancing, etc.)	
Time (Hours)		25. How much time does your child spend each day watching TV/videos, playing computer/ gaming systems, on tablet?	

Child's Name: ______

Yes	No	Please answer the following:
☐	☐	26. When riding in a car/truck, does your child use a car seat/booster?
☐	☐	27. When your child rides a bike/trike, does he/she wear a helmet?

Non-Food Allergies

28. Does your child have allergies or severe reactions to any of the following: ☐Yes ☐No
    If yes, please check only those that apply: 2

    ☐ 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:
☐	☐	29. Does your child take any medications? Please list ALL medications:
☐	☐	30. Will your child need to take any medications during scheduled programming? (Staff: Please review Medication Administration Procedure; additional action required)

Dental

Yes	No	Please answer the following:
☐	☐	31. Has your child complained about pain in the teeth or gums? If yes, please describe:
☐	☐	32. Does your child use fluoride toothpaste at home?
☐	☐	33. How many times per day does your child brush teeth at home?
☐	☐	34. 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)
☐	☐	35. Has your child visited the dentist?

Nutritional Information

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

Food Allergies, Intolerances, and Preferences

Yes	No	Please answer the following:
☐	☐	50. 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:

Yes	No	Please answer the following:
☐	☐	**51. 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**