Child Name _____________________________
DOB: _______________
Age: ______
Gender: M F

I. Preliminary Questions

1. How much did this child weigh at birth? Please circle one.
   a. Within normal range
   b. Low birth weight
   c. Underweight
   d. Overweight

   □ Yes  □ No

2. Has anyone in the family ever had any serious illnesses or abnormalities (e.g. heart disease, diabetes, cancer)?

   □ Yes  □ No

3. Were there any problems with this child immediately after birth? If yes, please explain.

   ____________________________________________________________

4. Is your child taking any medications every day? If yes, please explain.

   ____________________________________________________________

5. Will medication be needed at school? If yes, please explain.

   ____________________________________________________________

II. Has this child ever had the following illnesses? If so, please give date and explain below.

   □ Measles_________ □ Ear/Nose/Throat Problems_________ □ Eye Problems_________
   □ Mumps_________ □ Urinary/Kidney Problems_________ □ Heart Disease_________
   □ Chickenpox_________ □ Muscle/Bone Problems_________ □ Pneumonia_________
   □ Scarlet Fever_________ □ Anemia_________ □ Asthma_________
   □ Respiratory_________ □ Blood Pressure_________ □ Diabetes_________
   □ Tuberculosis_________ □ Rheumatic Fever_________ □ Intestinal Problems_________
   □ Seizures_________ □ Bee Sting Allergy_________

   Comments: ____________________________________________________________

III. Has your child ever had the following? If yes, please give date and explain.

   □ Hospitalizations
   □ Operations
   □ Other Health Problems/Illnesses
   □ Allergies to Medications (i.e. penicillin, sulfa drugs)

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

IV. Developmental History: Check the box if child.....

   □ Focus eyes and follow light or objects with eyes by 2 months?
   □ Coo and gurgle by 3 to 4 months?
   □ Sit alone on or before the 8th month?
   □ Walk alone on or before the 15th month?
   □ Say simple words on or before the 2nd year?
Toilet train on or before the 3rd year?

Mental Development appears normal?

Any concerns about your child's behavior? Where?  □ At Home  □ At School  □ In Public

Child is evaluated or has received a behavioral health diagnosis?

Would you like to be contacted by a Behavior Health Specialist?

Explain/Comments:

V. Immunization History

□ *Is child up-to-date on all immunizations appropriate for his/her age?

□ *Has child received all immunizations possible at this time but has not received all immunizations appropriate for his/her age?

□ *Has received no immunizations.

□ None of the above.

Explain/Comments:

VI. Dental Information

*Do you have dental insurance?  □ Yes  □ No

*Does the child have an ongoing source of continuous and accessible dental care?  □ Yes  □ No

Dentist Name:  ___________________________  Date of last visit:  ___________________________

□ Yes  □ No  Were there any problems for the child/comments:

VII. Nutrition Assessment

□ Yes  □ No  1. Does your child's weight appear normal?

□ Yes  □ No  2. Does your child eat fruits and vegetables?

□ Yes  □ No  3. If your child a picky eater now?

□ Yes  □ No  4. In the past six months, was your child found to be anemic (low blood iron)?

□ Yes  □ No  5. Is your child involved in active play daily?

□ Yes  □ No  6. Does your child have diarrhea frequently?

□ Yes  □ No  7. Does your child have constipation frequently?

□ Yes  □ No  8. Does your child vomit frequently?

□ Yes  □ No  9. Does your child drink from a baby bottle now?

□ Yes  □ No  10. Does your child have dental problems now?

□ Yes  □ No  11. Does your child have difficulty chewing or swallowing now?

□ Yes  □ No  12. Do you have concerns about your child’s growth, nutrition or eating?

□ Yes  □ No  13. Please explain if you answered yes to #12:  ___________________________

VIII. Food Substitution

□ Yes  □ No  1. Is your child restricted from foods due to religious, vegetarian, medical or personal beliefs? If yes, please check all that apply:

□ Pork  □ Beef  □ Poultry  □ Fish  □ Eggs  □ Milk

□ Other:  (Please specify)  ___________________________

□ Yes  □ No  2. Does your child have any food allergies or intolerances?
If yes, please check all that apply:

- Milk
- Milk Products
- Eggs
- All foods containing eggs
- Whole Wheat
- Shellfish
- Beef
- Legumes (Dry beans/Peas)
- Wheat Gluten
- Peanuts
- Soy
- Fish
- Tree Nuts/Seeds
- Vegetables, specify:
- Fruits/Juice, specify:

3. What kind of reaction does your child have when your child eats the specified food?

- Life Threatening
- Rash
- Diarrhea
- Swelling
- Difficulty breathing
- Other: ________________________________

4. Is your child on any special diet prescribed by a doctor?

   If yes, please specify: ________________________________

   NOTE TO STAFF - If yes to questions 2, 3, and/or 4 above: Parent must provide a physician's statement.

   Note: substitutions for non-medical reasons (i.e. religious, vegetarian, etc.) will be approved on a case-by-case basis with the Nutrition Manager or Nutritionist. Substitutions for medical reasons will be accommodated only with a signed statement from a licensed physician or other medical authority.

IX. Asthma/Allergy Screening

1. Has your child ever been diagnosed by a medical professional as having asthma?
   a) Date of diagnosis: ________________________________
   b) How many episodes per year: ________________________________
   c) Is it seasonal? At what time of the year do the episodes most often occur: ________________________________
   d) Is it well controlled? How: ________________________________

2. Has your child experienced any of the following due to asthma?
   - Treatment in ER: If yes, then # of times: ________________________________
   - Hospitalizations: If yes, then # of times: ________________________________

3. Have you ever given your child any medications for asthma?
   If yes, please check all that your child used in last year:
   - Albuterol
   - Intal
   - Ventolin
   - Pedia Pred
   - Tedral
   - Prelone
   - Proventil
   - Primitine Mist
   - Marax
   - Quilboron
   - Other: ________________________________

4. Does your child use a nebulizer or inhaler?

5. How many colds does your child have in a year?

6. Does your child suffer from hay fever or eczema?
7. Is your child allergic to any of the following?
If yes, please check all that apply:
- Animals
- Perfume
- Birds
- Pollen
- Grass
- Flowers
- Dust
- Trees
- Smoke
- Weather Changes
- Other: ________________________________

8. Does anyone in the household smoke? (i.e. home/car)

Comments: ____________________________________________

X. Medical Coverage
*Child receives medical services through ongoing source of continuous, Accessible Medical Care.

1. Does your family have a regular doctor or a regular place to receive health services?
If yes, please answer the following:

Doctor’s name: __________________________________________ Phone #: __________
Address: _______________________________________________

Please circle the answer to the following:
Medical Home Intervention
- Medicaid In Process Enrolled Denied Refused
- ARKids In Process Enrolled Denied Refused
- Indian Health Services In Process Enrolled Denied Refused
- Migrant Community Health Centers In Process Enrolled Denied Refused
- Private Insurance In Process Enrolled Denied Refused

2. Do you use the County Health Department for health care?
If yes, what city? __________________________ Date of last physical? __________

3. Do you have “regular”?  

4. Do you have “emergency only”?  

5. Do you have Healthy Families?  

6. Do you have private/other health insurance?
If yes, what is the name of the insurance? ________________________________

Comments: ____________________________________________

Signed By Staff: ______________________________ Date: __________
Parent/Guardian: ______________________________ Date: __________

MDCS (5/09)  HS-26 (d)