

CHILD HEALTH RECORD:

FORM 1, GENERAL INFORMATION

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____
 NAME OF INTERVIEWER: _____ TITLE: _____

1. PERSON INTERVIEWED _____
 DATE _____, RELATIONSHIP TO CHILD _____
 2. CHILD'S NICKNAME, IF ANY _____
 3. CHILD'S ADDRESS (Use pencil, keep current)

 _____ Zip Code _____
 PHONE _____
 4. FATHER'S NAME _____
 5. MOTHER'S NAME _____
 6. GUARDIAN'S NAME _____
 7. CHILD IS USUALLY CARED FOR DURING THE DAY BY

 PHONE _____, RELATIONSHIP _____
 8. LANGUAGE USUALLY SPOKEN AT HOME (If more than one, place "1" by primary language):
 _____ English _____ Spanish
 _____ Other _____
 9. SOURCE OF REIMBURSEMENT OR SERVICES (Circle "Yes" or "No" for each source. Use pencil, keep current)
 YES NO EPSDT/Medicaid (Latest certification No.):

 YES NO Federal, State or Local Agency:

 YES NO In-Kind Provider: _____
 YES NO Other (3rd party): _____
 ID NO.: _____
 YES NO WIC
 YES NO Food Stamps
 10. DATE OF CHILD'S LAST PHYSICAL EXAM

 11. DATE OF LAST VISIT TO DENTIST

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE
 (Name, address, and phone no.):
 Physician _____

 Clinic _____

 Hospital ER _____

 Other _____

 Dentist _____

13. IN CASE OF EMERGENCY NOTIFY
 (1) _____
 Relationship _____
 Phone _____ or _____
 (2) _____
 Relationship _____
 Phone _____ or _____
 (3) _____
 Relationship _____
 Phone _____ or _____

14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: (Transfer from Form 2A)
 Severe Asthma
 Diabetes
 Seizures, Convulsions
 Allergy, Bites _____
 Allergy, Medication _____
 Other _____

15. HOUSEHOLD INFORMATION (Please complete for family and household members).

	BIRTH DATE	LIVES WITH CHILD		FAMILY MEMBERS' HEALTH PROBLEMS
		YES	NO	
FATHER _____				
MOTHER _____				
BROTHERS & SISTERS (oldest first)				
(1) _____				
(2) _____				
(3) _____				
OTHER (Specify relationship)				
(1) _____				
(2) _____				
(3) _____				

(Use additional page if needed)

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

INTERVIEWER: GO TO FORM 2A

CHILD HEALTH RECORD:

FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER:

CHILD'S NAME: _____		SEX: _____	BIRTHDATE: _____
PERSON INTERVIEWED: _____		DATE: _____	RELATIONSHIP: _____
NAME OF INTERVIEWER: _____		TITLE: _____	
PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS CHILD'S BIRTH WEIGHT?			_____ lbs., _____ oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			<i>(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)</i>
HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT <i>(broken bones, head injuries, falls, burns, poisoning)?</i>			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			
HEALTH PROBLEMS	YES	NO	EXPLAIN <i>(Use additional sheets if needed)</i>
13. DOES CHILD HAVE FREQUENT _____ SORE THROAT; _____ COUGH; _____ URINARY INFECTIONS OR TROUBLE URINATING; _____ STOMACH PAIN, VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING <i>(Squint, cross eyes, look closely at books)?</i>		*	
15. IS CHILD WEARING <i>(or supposed to wear)</i> GLASSES?			<i>(If "yes") WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____</i>
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING <i>(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?</i>		*	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND <i>(Rear end, anus, butt)</i> WHILE ASLEEP?			
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?		*	<i>If "yes" ask: WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____</i>
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? <i>(Special consent form must be signed for Head Start to administer any medication).</i>			WHAT MEDICINE? _____ <i>(If "yes") WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? _____ HOW OFTEN? _____</i>
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			<i>(PHYSICIAN'S NAME: _____)</i>
21. HAS CHILD HAD: _____ BOILS, _____ CHICKENPOX, _____ ECZEMA, _____ GERMAN MEASLES, _____ MEASLES, _____ MUMPS, _____ SCARLET FEVER, _____ WHOOPING COUGH?			
22. HAS CHILD HAD: _____ HIVES, _____ POLIO?		*	
23. HAS CHILD HAD: _____ ASTHMA, _____ BLEEDING TENDENCIES, _____ DIABETES, _____ EPILEPSY, _____ HEART/BLOOD VESSEL DISEASE, _____ LIVER DISEASE, _____ RHEUMATIC FEVER, _____ SICKLE CELL DISEASE?		*	<i>If "yes", transfer information to Forms 1 and 5.</i>
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS <i>(Rash, itching, swelling, difficulty breathing, sneezing)?</i> a. WHEN EATING ANY FOODS? _____ b. WHEN TAKING ANY MEDICATION? _____ c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? _____		*	<i>If "yes", transfer information to Forms 1 and 5.</i> WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. <i>(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)</i> DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

* If starred (*) questions have "yes" answers, go to question 25.

CHILD HEALTH RECORD:

FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: _____ DATE: _____ RELATIONSHIP: _____

NAME OF INTERVIEWER: _____ TITLE: _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____ NO, _____ YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____ NO, _____ YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____ NO, _____ YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. (INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).

a. WOULD YOU SAY YOUR CHILD BEGAN TO _____ EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO _____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____ NO, _____ YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.



Kickapoo Head Start, Inc.

PHYSICAL EXAMINATION/ASSESSMENT FORM

Date of Service: _____ Child's Name _____ Sex: ___ Birthday _____

Screening Tests	Date	Results/Comments
Present Age		____ Years, ____ Months
Blood Pressure		
Hematocrit or Hemoglobin		
Height		
Weight		
Hearing		Left _____ Right _____
Lead		
Vision (Type of Test) a.Acuity b.Strabismus		Left _____ Right _____
Other Tests (Sickle Cell, etc.) _____		

Please List

Physical Examination/ Assessment	Normal For Age	Abnormal	Not Evaluated	Comments
1. General Appearance				
2. Posture, Gait				
3. Speech				
4. Head				
5. Skin				
6.Eyes: a.External Aspects				
b.Optic Fundisopic				
c.Cover Test				
7.Ears: a.External & Canals				
b.Tympanic Membranes				
8. Nose, Mouth, Pharynx				
9. Teeth				
10. Heart				
11. Lungs				
12.Abdomen (include hernia)				
13. Bones, Joints, Muscles				
14. Neurological/Social				
a.Gross Motor				
b.Fine Motor				
c.Communication Skills				
d.Cognitive				
e.Self-Help Skills				
f.Social Skills				
15. Glands (lymphatic/Thyroid)				
16. Other				

Findings, Treatment & Recommendation:

According to the Oklahoma EPDST this child is Up-To-Date: Yes No

Physician's Signature _____

Date _____

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

COMPLETE AT INTERVIEW

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____

PART I. TO BE COMPLETED BY HEAD START STAFF

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
 Topical Fluoride Application? No _____ Unknown _____ Yes _____
 Fluoridated water? No _____ Unknown _____ Yes _____
 Fluoride Supplement diet? (tablets _____, liquid _____) No _____ Unknown _____ Yes _____

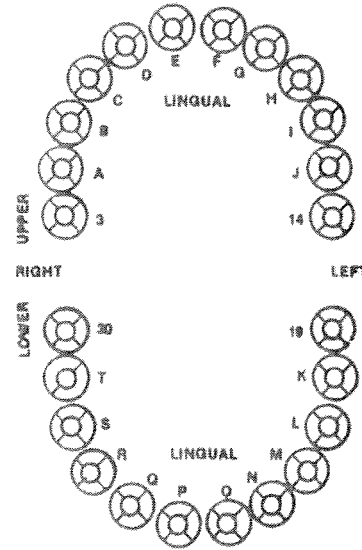
2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

3. CHILD (____ HAS, ____ HAS NOT) PREVIOUSLY SEEN A DENTIST.
 Dentist's name _____ Date last visit _____
 4. CHILD (____ IS, ____ IS NOT) UNDER A PHYSICIAN'S CARE.
 Physician's name _____
 5. CHILD (____ IS, ____ IS NOT) RECEIVING MEDICATION.
 Type _____
 6. CHILD IS REPORTED TO HAVE (Give details or attach Health History, Form 2A). YES NO YES NO
 Allergies _____ Liver Dis. _____
 Asthma _____ Rheumatic Fever _____
 Bleeding _____ Sickle Cell Dis. _____
 Diabetes _____ Other (List Below) _____
 Epilepsy _____
 Heart/Vascular Dis. _____

7. SOURCE OF REIMBURSEMENT OR SERVICES
 EPSDT/Medicaid
 Federal, State, or local Agency
 Head Start
 In-kind Provider
 Parents/Guardians
 Other (3rd Party)
 8. PRIORITY GROUP
 A. Needs Attention Immediately
 B. Needs Attention Soon
 C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: missing (☉), decayed (☉), or filled (☉); indicate restorations you perform in Item 10.



10. EXAMINATION AND TREATMENT RECORD (List recommended services in order).

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed			A.D.A. Procedure Number	Actual Charges (Fee)
				MO.	DAY	YR.		

11. DENTAL NEEDS (Check one or more and return 3 copies to Head Start after first visit).
 A. TREATMENT (restoration, pulp therapy, extraction) B. CLEANING C. FLUORIDE
 D. OTHER E. NO PROBLEMS

Approximate number of visits _____ Approximate cost _____

12. CHILD ORAL HEALTH SUMMARY (Complete and return 2 copies to Head Start after final visit).
 All planned treatment (____ is, ____ is not) complete. If not, explain here, as well as items checked.

- a. Routine recall visits
- c. Dietary problem(s)
- e. Harmful oral habits
- b. Special home emphasis, oral hygiene
- d. Developmental problem(s)
- f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature _____ Date _____

CHILD HEALTH RECORD:

FORM 6, NUTRITION

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE? _____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES? _____

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

	Yes	No	12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?	Approximate Number of Times a Week (circle the number(s) nearest to parent's answer)
3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS? (a) If "yes", what kind are they? _____			(a) Milk, cheese, yogurt.	0* 1* 2* 3 4 5 6 7 7+
(b) Do they contain iron?			(b) Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter.	0* 1* 2* 3 4 5 6 7 7+
(c) Do they contain fluoride?			(c) Rice, grits, bread, cereal, tortillas.	0* 1* 2* 3 4 5 6 7 7+
(d) Were they prescribed?			(d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.	0* 1* 2 3 4 5 6 7 7+
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS? *	*		(e) Oranges, grapefruit, tomatoes (fruit/juice).	0* 1* 2* 3 4 5 6 7 7+
5. IS YOUR CHILD ON A SPECIAL DIET? (a) What kind? _____	*		(f) Other fruits and vegetables.	0* 1* 2 3 4 5 6 7 7+
6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH? *	*		(g) Oil, butter, margarine, lard.	0* 1* 2 3 4 5 6 7 7+*
7. DOES YOUR CHILD TAKE A BOTTLE? *	*		(h) Cakes, cookies, sodas, fruit drinks, candy.	0 1 2 3 4 5 6 7 7+*
8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD? *	*			
9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING? *	*			
10. DOES YOUR CHILD OFTEN HAVE: (a) Diarrhea?	*			
(b) Constipation?	*			
11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS? *	*			

*Starred answers may require follow-up. Explain details or give additional comments here.

PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST

13. GROWTH				14. ANEMIA SCREEN			
DATE	AGE	HEIGHT (no shoes, to nearest 1/8 in.)	WEIGHT (light clothing, to nearest 1/4 lb.)	DATE	HEMOGLOBIN*	OR HEMATOCRIT *	
_____yrs. _____mo.				SCREENING			
_____yrs. _____mo.				RESCREENING			
_____yrs. _____mo.				* Hgb less than 11 or Hct less than 34 require follow-up			

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION

(Review items 2 through 13. If there are answers in starred (*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)

- | | |
|---|---|
| <input type="checkbox"/> Suspect dietary problem or inadequate food intake (from Questions 2 to 12) | <input type="checkbox"/> Overweight (weight greater than typical, from Growth Chart 1 or 4) |
| <input type="checkbox"/> Hgb. less than 11 gm. or Hct. less than 34% (from Question 14) | <input type="checkbox"/> Short for Age (height less than typical, from Growth Chart 2 or 5) |
| <input type="checkbox"/> Underweight (weight less than typical, from Growth Chart 1 or 4) | <input type="checkbox"/> Wt. for Ht. (greater or less than typical, from Growth Chart 3 or 6) |

COMMENTS (use additional page if needed)

Signature _____ Title _____ Date _____