Child Health / Nutrition Form

Child's Name:_____ Sex: Male / Female D.O.B._____

Height: _____ Weight: _____

SOURCE OF CARE: Medical Home / Dental Home	SOURCE OF PAYMENT FOR MEDICAL SERVICES (Circle Yes or No): Health Insurance
Primary Care Provider:_____ Address:_____ _____ Phone:_____ Dental Provider:_____ Phone: _____	Yes No Managed Medicaid (Buckeye, Care Source, Molina, United Health Care) Yes No Straight Medicaid Yes No Private(Name)_____ Yes No No Insurance (Date Complete Combined Programs Application)_____

MEDICAL INFORMATION:	Yes	No	Explain for all items marked "Yes"	2nd	3rd
Were there any complications with your pregnancy with this child?					
Were there complications prior to or immediately following delivery?					
Was anything wrong with your child at birth or while in nursery?					
Has your child ever been hospitalized, had serious accident or serious illness? (ODJFS01234)					
Does your child have frequent sore throat, cough, urinary difficulties, stomach pain, diarrhea, vomiting?					
Does your child have problems with eyes/seeing – squints, cross-eyed, looks closely to read?					
Does your child wear (or suppose to) glasses? Last Visit_____					
Does your child have problems with ears/hearing - ear pain, frequent earaches, drainage, favors 1 ear?					
Does your child have any allergies? (ODJFS01234) Medication_____ Food_____ Environmental_____			** Complete ECDHS402 prior to entry if allergy require staff to monitor child for symptoms, take action if a reaction occurs or emergency medication required*		
Does your child take any medication or require a modified diet/ food supplement? (ODJFS01234) Will Head Start Administer?			** Complete ODJFS01217 if Head Start administer, physician only completes #2 and ECDHS402 prior to entry*		
Does the child have any other special health/medical condition, diagnosed by physician (ex. asthma, bleeding, diabetes, seizure/epilepsy, heart condition or any other childhood disease)? (ODJFS01234)			** Complete ECDHS402 prior to entry if condition requires staff to perform a procedure, monitor child for symptoms, or administer medication*		
Does anything mentioned above affect the child's participation in everyday activities (or limitations to participating)?					

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Child's Name:_____

NUTRITION INFORMATION:	2nd	3rd
Does your child have trouble chewing or swallowing? Yes / No Explain:_____		
_____		
Does your child use a (circle all that apply): *cup spoon fork knife sippy cup bottle take a bottle to bed*		
How many times a week does your family dine out or eat takeout food? _____		
Do you give your child: *Vitamins/Minerals Fluoride Iron Other Other*_____		
What does your child drink most days? *Breast Milk Milk Juice Fruit Drinks Water Soy Milk Formula Pop Energy Drinks Tea Pediasure Other*_____		
What does your child eat most days? **Breakfast:** _____ **Lunch:** _____ **Supper:** _____ **Snack:**_____		
Has there been a big change in your child's appetite? Yes / No _____		
Does your child receive services from WIC? Yes / No		

Explanation for 2nd year updates (refer to items indicated with √):_____

_____

_____

_____ **Parent Initials / Date** _____

Explanation for 3rd year updates (refer to items indicated with √):_____

_____

_____

_____ **Parent Initials / Date** _____

_____ _____

Parent Signature **Date** **Staff Signature** **Date**

Reviewed 1/16