Health and Developmental History

CHILD'S NAME: _____ D.O.B.: _____

MEDICAL	
Do you have medical Coverage/Insurance? **Insurance Number _____**	□ YES □ NO
Does your child have a doctor that examines him/her regularly?	□ YES □ NO
Name of Dr./Clinic _____ Name of Dr./Clinic _____	
Date of Last Well Child: _____	
Does your child see a Medical Specialist for any reason?	□ YES □ NO
Does your child have allergies? Is he/she under a doctor's care for allergies? (such as food)	□ YES □ NO
Is he/she taking any medication on a regular basis?	□ YES □ NO
Will he/she need to take medication during class hours?	□ YES □ NO
Does he/she have any health conditions that get in the way of everyday activities? (such as seizures, diabetes, asthma, eczema)	□ YES □ NO
Is your child current on Immunizations?	□ YES □ NO
Do you choose to exempt your child from immunizations?	□ YES □ NO

Please explain any "YES" answers::

_____
_____
_____
_____

DENTAL	
Does your child have a dentist?	□ YES □ NO
Name of Dentist/Clinic: _____	
Date of Last Exam: _____	
Does your child use a bottle or sippy cup?	□ YES □ NO
Does child have any untreated tooth decay?	□ YES □ NO

Please explain any "YES" answers:

_____
_____
_____
_____

VISION/HEARING	
Does your child wear eye glasses?	□ YES □ NO
Do you have any concerns about his/her sight?	□ YES □ NO
Does your child have tubes in his/her ears?	□ YES □ NO
Do you have any concerns about his/her hearing?	□ YES □ NO

Please explain any "YES" answers:

_____
_____
_____
_____

NUTRITION	
Do you have any concerns about your child's eating patterns?	□ YES □ NO
Is your child on a special diet?	□ YES □ NO
Is your child restricted from foods due to religious, vegetarian medical or personal beliefs	□ YES □ NO
Does your child have any food allergies or intolerances?	□ YES □ NO
Does your child eat dirt, clay or other non-food items?	□ YES □ NO
Is your child anemic?	□ YES □ NO
Does your child have constant digestive issues (constipation/diarrhea)?	□ YES □ NO
Do you have any concerns concerning your child's growth, nutrition or eating?	□ YES □ NO

Please explain any "YES" answers:

_____
_____
_____
_____

MENTAL/BEHAVIOR HEALTH	
Does your child receive mental health services (counseling or therapy)? **IF YES: Provider: _____**	□ YES □ NO
Does your child receive services for developmental concerns (autism, speech, sensory)? **IF YES FOR/WHERE** **_____**	□ YES □ NO
Does your child have an IEP or IFSP? **IF YES FOR** _____	□ YES □ NO
Has your child been evaluated or being evaluated for a developmental concern?	□ YES □ NO

Has your child been diagnosed with a behavioral health concern?	□ YES □ NO
Any changes in child's life in last 6 months?	□ YES □ NO
Do you have any concerns about your child's behavior?	□ YES □ NO

Please explain any "YES" answers:

_____
_____
_____
_____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____