BBNA Head Start

PO Box 310 Dillingham, AK 99576
907-842-4059

HEALTH HISTORY

CHILDS NAME:_____ BIRTH DATE:___/___/_____COMMUNITY: _____

FAMILY HISTORY	YES	NO	PLEASE EXPLAIN "YES" RESPONSES
ALLERGIES			
Does your child have any seasonal allergies? (please list)			
Any allergies to medicine? (what medicines)			
When your child has allergic reaction what happens? Hives or can't breathe? Will he or she need to be given shots? Please be specific.			
HOSPITALIZATION/SERIOUS ILLNESS			
Has child ever had surgery that required hospitalization?			
Has child suffered any of the following: (head injury, broken bones, burns, poisoning)?			Date(s):
Has child ever had a serious illness such as meningitis?			
HEALTH CONCERNS			
Does child have **frequent:** (*please circle applicable responses*) sore throat, cough, vomiting, diarrhea, constipation, stomach pain, urinary tract infections?			If yes, has child been treated?
Do you have specific concerns about your child's health ***or*** behavior at this time?			
Does child have ear trouble such as (*please circle*): frequent earaches *or* complaints of ear infection, ear discharge, rubs/pulls ear, tubes in ears?			
Has your child had a recent physical?			Date:
Please list all medicines your child is taking **currently**:			
Does child have (please circle): asthma, seizures, respiratory problems, other _____?			Date:
Is your child exposed to second hand smoke?			
ORAL HEALTH/DENTAL			
Does child appear to have trouble with teeth or gums?			
Has child received a recent dental exam?			Date:
VISION			
Have you observed your child squinting, crossing eyes, or holding objects very close to his/her eyes?			
Has an eye doctor performed a vision exam on your child?			
Does child wear glasses (or need to be wearing glasses) at this time?			Glasses worn since:

Parent/Guardian signature: _____ Date: _____

White: Main Office Yellow: Site Files