Central Mississippi, INC

HEAD START/EARLY HEAD START HEALTH HISTORY

CHILD HEALTH HISTORY/ASSESSMENT

Assurance of Confidentiality: All of the information you provide help us to deliver services most appropriate for your family needs. You may prefer not to share some information with us. However, some information is required to determine eligibility. All information is held strictly confidential.

These questions are being asked to determine risk factors that may affect the enrollee's current health.

Enrollee's _____ Date of Birth _____
First Name MI Last Name

Type of funding: Medicaid ____ Chips ____ Private Insurance___ No Insurance ____

Card Number or policy Number: _____

Child's Doctor/Clinic: _____ Child's Dentist _____

CHILD HEALTH ASSESSMENT

Has this child ever experience any of the following acute conditions?

	Date of most recent occurrence:
Asthma	_____
Anemia	_____
Meningitis	_____
Convulsions/seizures	_____
Ear Infections	_____
Lead poisoning	_____
Intestinal parasites	_____
Head injury	_____
Inadequate diet	_____
Feeding/eating problems	_____
Diabetes	_____
Chicken Pox	_____
Other	_____
None Experienced	_____

Comments:

_____

_____

Please list any allergies: Medications: _____

Food: _____

Other: _____

If any allergies, list the name of the physician that diagnosed child with the above allergies:

_____

_____

Is this child currently taken any prescription medications? □ Yes □ No

Please list any: _____

_____

Child Health Assessment

Prenatal/Birth History

Prenatal History

Time mother first receives prenatal care:

- ☐ First 3 months of pregnancy
- ☐ Middle 3 months of pregnancy
- ☐ Last 3 months of pregnancy
- ☐ No prenatal care
- ☐ Don't know

Prenatal Exposure:

- ☐ Cigarettes/Tobacco
- ☐ Alcohol
- ☐ Non-prescription drugs, specify: _____
- ☐ Prescription drug, specify: _____

Birth History

Delivery location: ☐ Hospital ☐ Birthing Center ☐ At home ☐ Don't know

Was this child born… ☐ About on time Gestational Age: _____ weeks
☐ More than 2 months early
☐ 2 months to 3 weeks early
☐ More than 3 weeks late
☐ Don't know

Birth Weight/Length (or nearest estimate): _____ Pounds _____ Ounces
_____ Inches

Reason for non-routine hospital stay: _____

Observable birth defects: _____

DEVELOPMENTAL ASSESSMENT

DEVELOPMENTAL RISK FACTORS:

Established Risks **Have you ever been told by your health professional that your child has any of the following:**

Yes	No	
☐	☐	A chromosomal abnormality, such as Down Syndrome
☐	☐	A congenital birth defect, such as cleft lip &/ or palate
☐	☐	A congenital syndrome, such as Fetal Alcohol Syndrome
☐	☐	HIV positive/AIDS
☐	☐	A sensory impairment, such as a hearing or vision Impairment
☐	☐	Is medically fragile, describe: _____ Other, specify

Biological/Medical Risks

Yes	No	
☐	☐	An abnormal neurological finding, such as seizures, microcephaly or marcocephaly
☐	☐	Asphyxia
☐	☐	A central nervous system infection/trauma
☐	☐	A major congenital anomaly such as craniofacial Anomaly
☐	☐	Congenital heart disease
☐	☐	Sickle cell anemia
☐	☐	Diabetes
☐	☐	A sibling with documented disabilities
☐	☐	Evidence of prenatal exposure to drugs
☐	☐	Birth weight under 1500 grams or prematurity (less than 32 weeks)
☐	☐	Nutritional deficits, such as failure to thrive
☐	☐	Severe chronic illness, describe: _____
☐	☐	HIV positive child or mother
☐	☐	Other, specify: _____

CHILD ORAL HEALTH/CONSENT FOR FLUORIDE SUPPLEMENT

Number of times per day child brushes teeth: _____

Does your child take any fluoride by mouth? ( ) Yes ( ) No
If your answer is yes, please give the name: _____

( ) I want my child to receive the fluoride supplement in toothpaste.
( ) I do not want my child to receive the fluoride supplement in toothpaste.

What type of water source does your home utilize?

□ City water □ Rural water □ Well water □ Use only bottled water

Do you have concerns about the safety of your water?

□ Yes □ No

Central MS, Inc. Head Start Program in cooperation with the Mississippi State Board of Health and the Dental Society and in accordance with federal and state guidelines are offering topical fluoride treatments to all students during their dental examinations. Your child will receive a fluoride supplement on the initial visit to the dentist pending we have your consent.

This is a preventative program and doesn't take the place of regular dental care. Participation is entirely voluntary. Fluoride supplements are considered a valuable part of your child's dental health program.

I certify that the information provided in this enrollment application is accurate and truthful to the best of my knowledge.

Signature: _____
(Parent/Guardian)

Date: _____/_____/_____

AGENCY USE ONLY:

Staff Signature: _____

Date: _____/_____/_____