

Child: _____ D.O.B. ___/___/___ age _____ Area/Class # _____

Staff completing form (FA/HBT) _____ Intake Date _____ Update Date _____

Date CB Teacher reviewed _____ CB Teacher Signature _____

PREGNANCY/BIRTH HISTORY

- 1) List problems mother had during pregnancy/delivery _____
- 2) Birth weight ____lb. ____oz. Birth length _____ in. Premature Yes ____wks. No
- 3) List anything wrong at birth _____

****THE FOLLOWING ON THIS PAGE IS FOR CENTER BASED ONLY****
HBT DO NOT CROSS OUT

PHYSICAL, PSYCHOLOGICAL, SOCIAL DEVELOPMENT

- 1) Is your child completely toilet trained? Yes No If no, do you want us to work on this at school? Y N
*If yes, a "Toilet Training Agreement" will be completed during Teacher's first Education Visit.
- 2) What time does your child go to bed at night? _____ Get up in morning? _____
- 3) Is your child in diapers? Yes No If yes, **what size?** _____ List any special diapering instructions:

*Are diaper ointments needed? Yes No If yes, parent must bring own supply labeled with child's name and sign below. **If ointment is an RX, a Medication Form must be filled out.**

I give permission for _____ ointment to be used for diapering.

Parent signature _____
(If this changes, list on page 3 and have parent sign and date)

- 4) Does your child have separation problems? Yes No What routine works best for you and your child when leaving your child? _____
- 5) What **self-help skills** does your child need help with? _____
- 6) Is there anything else we should know about your child? _____

PACT provides Equate Dry Skin or Vaseline Intensive Care Lotion or for hands that become chapped
PACT provides Rocky Mountain Sunscreen (SPF 50+) Active Ingredients: Octinoxate 7.5%, Homosalate 10%, Oxybenzone 4% Octisalate 5%

Yes No I give permission for my child to use hand lotion as needed if hands become chapped.
Yes No I give permission for the teacher to apply sunscreen on my child when outdoors in the summer.
Yes No I give permission for the teacher to apply vanilla (for buffalo gnats) on my child when outdoors.

Parent/Guardian Signature _____ Date _____

**** If parent needs a different brand of item above then a written statement from doctor is required.**

FA: Emails to Health Coord. / Copy to DCFS file / Original to CBT for Health & Safety Notebook
HBT: Emails to Health Coord. / Original – HB Teacher File

HEALTH HISTORY

Child _____

Area/Class# _____

	HEALTH PROBLEMS	EXPLAIN & LIST DETAIL FOR "YES" ↓	Yes	No
1.	Has child ever been hospitalized, operated on or had a serious illness?			
2.	Does child have any of these frequently? (circle) sore throat, cough, urinary problems, stomach pains, vomiting, diarrhea			
3.	Does child have any eye problems?			
4.	Is there a family history of eye problems? If yes, circle who? (Mom, Dad, Sister, Brother, Aunt, Uncle)			
5.	Does child have problems with ears/hearing?			
6.	Is there a family history of hearing loss? If yes, circle who? (Mom, Dad, Sister, Brother, Aunt, Uncle)			
7.	Does child have asthma? CB-If yes complete <i>Authorization for release of Medical Plan</i> HB-If yes complete <i>Medical or Dietary Alert Emergency Health HB</i>			
8.	Does child have? (circle) convulsions, seizures, bleeding tendencies, diabetes, epilepsy, heart disease, liver disease, sickle cell disease CB-If yes complete <i>Authorization for Release of Medial Plan</i> HB-If yes complete <i>Medical or Dietary Alert Emergency Health HB</i>			
9.	Will child need to take medication during PACT class or activities? (If yes, Teacher must complete a <i>Medication</i> form with parent prior to child starting class unless it is related to # 7 or # 8 above where medication is included on Medical Alert)			
10.	Besides anything related to #7 or #8 above, does child take medicine routinely at home? If yes, Name _____ Why taken? _____ _____ Possible reactions: _____			
11.	Does child have severe non-food allergies that would require emergency attention while at school? (Example- bee sting.) CB-If yes complete <i>Authorization for Release of Medical Plan</i> HB-If yes complete <i>Medical or Dietary Alert Emergency Health Plan HB</i>			
12.	Does child have non- food mild allergies that would not require emergency attention at school? If yes, explain and include symptoms.			
13.	Is child allergic to any medication? If yes, list medication and include on <i>Emergency Care Information</i> form.			
14.	Does child have any physical restrictions that have not been included in any question above?			
15.	Does child have any other health problems?			

Family Advocate or HB Teacher must list all medical alerts and medication allergies on Emergency Care form.
(# 7, 8, 11, 13)

HEALTH HISTORY

Child _____

Area/Class# _____

	NUTRITIONAL ASSESSMENT	EXPLAIN & LIST DETAIL FOR "YES" ↓	Yes	No
16.	Does your child take vitamins & mineral supplements? (Iron, fluoride, Rx)			
17.	Does your child have any food allergies? CB- If yes, complete a <i>Dietary</i> form and obtain <i>Authorization for Release of Medical Plan</i> if needed HB – If yes, complete a <i>Dietary</i> form and <i>Medical or Dietary Alert Emergency Health Plan</i> HB - <u>if medication is needed</u>			
18.	Is there any food your child should not eat for religious reasons? If yes, FA or HBT complete a <i>Dietary</i> form			
19.	Is your child on a special diet or have special dietary needs such as food additives (Other than the food allergies above)? CB- If yes, complete a <i>Dietary</i> form and obtain <i>Authorization for Release of Medical Plan</i> HB – If yes, complete a <i>Dietary</i> form			
20.	Has there been a big change in your child’s appetite in the last month that you are concerned with?			
21.	Does your child eat or chew things that are not food? (What? Swallow?)			
22.	Does your child have trouble chewing or swallowing?			
23.	Does your child often have: (a) Diarrhea? (b) Constipation?			
24.	Do you have any concerns about what your child eats?			
25.	Is child on baby foods and/or formula due to age? (Less than 15-24 months) If yes, complete an <i>Infant Report from Parent</i> form. (CB only)			
26.	I understand I cannot send food items to PACT functions as stated in the Parent Handbook (excludes EHS socializations with infants)			

I have reviewed the information on this form and agree it is accurate. I also understand that if my child was marked as having a condition that may require emergency attention at school, that the plan signed by the physician and any medication indicated on the plan must be in place at school before my child can attend. This could be from # 7, 8, 9, 11, and 17, 19 above.

Parent/guardian signature _____ date _____

Go to page 4 for updates to Health History throughout the year → → →

HEALTH HISTORY

Child _____

Area/Class# _____

****Updates ONLY: (Copy all pages when sending to Health Coordinator) ****

Diaper Ointment & Instructions:		
Health Problems:	#	Explain, list details, and obtain proper releases if needed
Nutritional Problems:	#	

Parent/guardian signature _____ date _____