Barrow Early Learning Center

CHILD HEALTH HISTORY

CHILD'S NAME ______________________________ BIRTHDATE_________________

To be completed and signed by the parent or guardian:

HOSPITALIZATIONS AND ILLNESSES (UK=unknown)	**YES**	**NO**	**UK**	**EXPLAIN YES ANSWERS**
Has your child ever been hospitalized or has surgery?				
Has your child ever had a serious accident? (broken bones, head injuries, falls, burns, or poisoning)				
Has your child ever had a serious illness?				
BIRTH HISTORY				
Was your child born more than 3 weeks early or late?				
What was your child's weight at birth?				
Were there any complications during birth or first few months?				
Did your child stay in the hospital for medical reasons longer than usual?				
HEALTH HISTORY				
Has your child ever had: __Asthma __Blood Vessel Disease __Boils __Chicken Pox __Diabetes __Eczema __Epilepsy __Heart Disease __Hives __Hepatitis A/B __Impetigo __Liver Disease __Measles __Meningitis __Mumps __Polio __Rheumatic Fever __Scarlet Fever __Sickle Cell Disease __Tuberculosis __Whooping Cough __Allergies __Other: Please explain				
Does your child have any conditions that would get in the way of everyday activities?				
Did a doctor or healthcare professional diagnose your child? Please explain: When? How?				
Does your child have frequent: __Sore Throat __Cough __Ear Infection __Vomiting __Urinary Infection/Trouble Urinating __Stomach Pain __Diarrhea __Constipation __Other: Please explain				
Is your child taking any medications? If yes, what medication and for what?				
Is a doctor/physician treating your child now? If yes, for what? Please provide doctor's name and phone:				
Have you ever noticed your child scratching his/her anal area while sleeping?				
Has your child ever had a convulsion or seizure? If yes, when did it happen and/or how often does it occur?				
Is your child taking medication for seizures?				
HEARING AND VISION HISTORY				
Does your child have vision difficulties? (Squint, Crossed Eyes, etc.)				
Does your child wear or is supposed to wear glasses? If yes, has your child had a checkup within the year?				
Does your child have problems with hearing? (Ear pain, discharge, rubbing or favoring on ear, have or had ear tubes?)				
DENTAL HISTORY				
Has your child been to the dentist? When was the last visit?				
Does your child have any trouble with their teeth, teething, gums and/or mouth?				
OTHER: Is there anything else you would like us to know?				

PARENT/GUARDIAN SIGNATURE ____ DATE___________________

PARENT PRINTED NAME____