

## BLAIR COUNTY HEAD START HEALTH HISTORY

FOR OFFICE USE ONLY: T/TA: \_\_\_\_\_ FSHA: \_\_\_\_\_ START DATE: \_\_\_\_\_ (F.C.: LIT ML FC AI)

**PLEASE FILL OUT THE FOLLOWING INFORMATION!**

(ALL THIS INFORMATION IS STRICTLY CONFIDENTIAL AND WILL BE SHARED WITH THE APPROPRIATE PROGRAM STAFF)

**CHILD'S NAME:** \_\_\_\_\_ **CHILD'S BIRTH DATE:** \_\_\_\_\_

**CHILD'S PRIMARY MEDICAL INSURANCE AND CARD #** \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE** \_\_\_\_\_

**PARENT'S NAME** \_\_\_\_\_ **PARENT MEDICAL INSURANCE** \_\_\_\_\_

Mental/Emotional/Behavioral & Physical	YES	NO	Comments
Hyperactivity			
Attention Deficit			
Bedtime (what time)			
Nightmares			
Other			
<b>Head/Neck:</b> Tubes in ears			
Nose bleeds			
Seizures			
Ear infections			
Glasses			
Hearing aids			
Other			
<b>Heart/Lungs:</b> Asthma			
Allergies			
Heart disease			
Other			
<b>Bowel/Bladder:</b> Wetting during day			
Bed wetting			
Constipation			
<b>Bones/Skin:</b> Eczema/psoriasis			
Other			
<b>Screening:</b> Anemia			
TB			
Lead			
Has your child ever eaten Plaster, wood etc?			
<b>Nutrition:</b> Overweight/ Underweight			
Food allergies (doc. By MD)			
Food intolerances			
Personal/Religious food preferences?			
Diabetic			

