

FSA Child Care HEALTH, DIET, DEVELOPMENTAL HISTORY (PRESCHOOL)

Child's name _____ Date _____

What are your child's abilities? What are your child's interests? What does your child like to do or play with?

We would like to include your child's home life and culture in the classroom. What would you like us to know about your family's culture and favorite activities?

BIRTH INFORMATION

Place of birth _____ Birth date _____ Birth weight _____
Problems at birth? (i.e., jaundice, oxygen needed, etc.) _____

HEALTH HISTORY

Please indicate any illnesses/problems your child currently has or has had in the past.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Eczema	<input type="checkbox"/> Vision/wears glasses or patch
<input type="checkbox"/> Anemia/sickle cell	<input type="checkbox"/> Exposure to TB	<input type="checkbox"/> serious accidents/injuries
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Surgery/hospitalization
<input type="checkbox"/> Bowel/bladder accidents	<input type="checkbox"/> Hearing/ear problems	<input type="checkbox"/> Constipation/Diarrhea
<input type="checkbox"/> Seizures	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bone/muscle	<input type="checkbox"/> cancer	<input type="checkbox"/> Medical Alert
<input type="checkbox"/> Other: _____		

Please explain any items checked above: _____

Do you have any concerns about your child's health? Yes No

If yes, what? _____

Does your child take any medication on a regular basis? Yes No

If yes, what? _____

Please describe any special needs or help your child will need to participate in classroom activities:

LEAD EXPOSURE RISK

Check any of the items that pertain to your child/family. These are possible lead exposure risks.

Parent concerned child was exposed to lead
 Child has lived in a home built before 1960
 Family used utensils made of clay and/or teas made in Mexico
 Child lives near a factory/mine releasing lead
 Family member works around lead products

DIET HISTORY

How would you describe your child's appetite? ___ Good ___ Fair ___ Poor

What foods does your child like? _____

What foods does your child dislike? _____

What is his/her favorite snack? _____

Does your child eat clay, paint chips, dirt, or anything else that is not usually considered food? _____

 If yes, what? _____

Does your child have swallowing problems? _____

 Describe _____

What eating utensils does your child use? ___ Fork and spoon ___ specially adapted utensils ___ other

Do you have any questions about your child's diet? ___ Yes ___ No

 If yes, what? _____

Do children and adults eat together in your household? ___ Usually ___ Sometimes ___ Not usually

Are there any foods your child should not eat due to allergies, sensitivity, special diet or any other reason?

 What foods: _____ Reason: _____

(If your child has any food allergies, we will need a doctor's note on file indicating which foods your child may not have)