Washita Valley Community Action Council

CHILD HEALTH INFORMATION – 1 Child's name: ______________________

MEDICATION

Is your child currently taking any medications? Yes No

If "Yes", what type? ____

Will this medication need to be given during school class time? Yes No

GENERAL HEALTH HISTORY

Please check any of the following health conditions that you think your child has:

Does your child have any or the following health conditions?

 Anemia or Sickle Cell Anemia Asthma Diabetes Seizure Disorders

Allergies To:

 Bee Stings Food Insect Bites Medication Poison Oak or Ivy

Sinus/Skin Problems:

 Eczema, hives, skin problems Seasonal Allergies

Bowel/ Urinary Tract Problems:

 Bed wetting frequent diarrhea frequent urination Wears diapers
 Daytime wetting frequent constipation Painful urination

Vision Problems:

 born more than 6 weeks premature Difficulty seeing Headaches Wears glasses

Hearing Problems:

 Difficulty hearing frequent earaches Tubes in ears

Digestion Problems:

 Frequent Indigestion Frequent Stomachaches Frequent Vomiting

Other Conditions:

 Bites when angry/ frustrated Fainting spells Hyperactivity Bone, joint or muscle disease
 Frequent fevers Lack of energy/ tire Trouble sleeping Bone, joint or muscle injury

Other (Explain): ____

ANY SPECIAL CONCERNS (explain below)

Please comment on any special concerns you have about your child:

____

____

____

____

____

CHILD HEALTH INFORMATION – 2

Child's name: ____________________________

MEDICAL

Do you have medical coverage/ insurance? Yes No

If "Yes", what type? Medical card Recipient ID#_________________
Private insurance Recipient ID#_________________

Please give insurance provider's name (e.g. Blue Cross, Providence, etc.)

Does your child have a doctor that examines him/her regularly? Yes No

If "Yes", who? ______________________________

Is your child seeing a medical specialist for any reason? Yes No

If "Yes", who? _______________________________

DENTAL

Do you have dental coverage/ insurance? Yes No

If "Yes", what type? Medical card Recipient ID#_________________
Private insurance Recipient ID#_________________

Please give insurance provider's name (e.g. Blue Cross, Providence, etc.)

Does your child have a dentist that examines him/her regularly? Yes No

If "Yes", who? ______________________________

Is the child in pain right now because of their teeth? Yes No

NUTRITION

Is your family currently involved with WIC? Yes No

Do you have any concerns about your child's eating patterns? Yes No
(E.g. picky eating, under eating, overeating, other)

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

Does you child have problems chewing or swallowing? Yes No

Does your child use a bottle? Yes No

SPECIAL NEEDS

Is the child currently seeing a counselor or therapist? Yes No

If "Yes", who? ____

Is your child currently receiving Sooner Start Services? Yes No
(E.g. speech/ language, physical therapy, etc.)

If "Yes", who? (Agency Name) ____

Address ___________________________________ City____________________________________

Child Oral Health Assessment

Washita Valley Head Start * 205 W Chickasha Ave. suite 5 * Chickasha, OK 73018 * (405) 224-5831

Appointment Date: ____/_____/_____ Child name: _____________________________ Center: ____________

Exam Completed by: ☐ DMD ☐ RDH Other: ____

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center Other: _______________________________

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of times per day child brushes teeth: |____|____|

Uses fluoride toothpaste: Yes No Takes fluoride supplement: Yes No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Condition:

____
____
____
____

Today's Visit:	Treatment:
☐ Visual Screening ☐ Full Exam ☐ X-Rays ☐ Cleaning ☐ Fluoride Treatment ☐ Oral Hygiene Instruction ☐ Treatment (specify) _________________________ _________________________ _________________________ _________________________ _________________________ _________________________ _________________________	☐ No need ☐ Treatment Needed **Next Appointment Date:** _______/_________/________ Treatment Plan: _________________________ _________________________ _________________________ _________________________ _________________________ _________________________ _________________________ _________________________

Providers Signature: ____________________________________Completion Date: ______/______/______

Printed Name of Provider: ________________________________

Address: ____________________________________ Phone: _______________________

Revised 3/2010

Child Physical Exam

Washita Valley Head Start * 205 W Chickasha Ave. suite 5 * Chickasha, OK 73018 * (405) 224-5831

Child Name: ____ Exam Setting: ☐ Clinic ☐ School/Center

Exam completed by: ☐ MD ☐ FNP ☐ PA ☐ RN ☐ LPN Other (specify):_________________________

Physical Exam/Assessment

Blood Pressure: ________________________ Height: ____________________ Weight: __________________

	NORMAL	ABNORMAL	REFERRED	NOT EVALUATED	**Comments:**
General Appearance	☐	☐	☐	☐	
Posture, Gait	☐	☐	☐	☐	
Speech	☐	☐	☐	☐	
Head	☐	☐	☐	☐	
Skin	☐	☐	☐	☐	
Eyes External Aspects	☐	☐	☐	☐	
Optic Fundoscopic	☐	☐	☐	☐	
Cover test	☐	☐	☐	☐	
Ears External Canal	☐	☐	☐	☐	
Nose, Mouth, Pharynx	☐	☐	☐	☐	
Teeth	☐	☐	☐	☐	
Heart	☐	☐	☐	☐	
Lungs	☐	☐	☐	☐	
Abdomen (includes hernia)	☐	☐	☐	☐	
Genitalia	☐	☐	☐	☐	
Bones, Joint, Muscles	☐	☐	☐	☐	
Glands (lymphatic/ thyroid)	☐	☐	☐	☐	
Muscular Coordination	☐	☐	☐	☐	
Other______________________	☐	☐	☐	☐	

Iron Level: HCT: _________ HGB: _________

*Lead Level: __________ ug/dL finger prick (If ≥ 10ug/dL then ____________ venous blood draw)

*(if parent is unable to provide written documentation that their child received lead screening blood test at ages 12 and 24 months, EPSDT and Head Start require children receive a lead screening blood test between the ages of 36 and 72 months.)

Allergies: ____

Medications: ____

Immunizations given at this time: ____

Treatment or Follow-Up needed: Yes No

Date of Next Appointment: ____/______/______

Comments:

Provider Signature: ___________________________________ Exam Date: _______________________

Printed or Stamped Name and Address of Provider: