

Appendix C: Blank Records & Forms

Handout C: Child Health Record Sample (Part 1)

CHILD HEALTH RECORD:

FORM 2A, HEALTH HISTORY

PERSON INTERVIEWED: _____		DATE: _____	RELATIONSHIP: _____
NAME OF INTERVIEWER: _____		TITLE: _____	
PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS CHILD'S BIRTH WEIGHT?			_____ lbs., _____ oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)
HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			
HEALTH PROBLEMS	YES	NO	EXPLAIN (Use additional sheets if needed)
13. DOES CHILD HAVE FREQUENT _____ SORE THROAT; _____ COUGH; _____ URINARY INFECTIONS OR TROUBLE URINATING; _____ STOMACH PAIN, VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING (Squint, cross eyes, look closely at books)?		*	
15. IS CHILD WEARING (or supposed to wear) GLASSES?			(If "yes") WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?		*	
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND (Rear end, anus, butt) WHILE ASLEEP?			
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?		*	If "yes" ask: WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? (Special consent form must be signed for Head Start to administer any medication).			WHAT MEDICINE? _____ (If "yes") WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? _____ HOW OFTEN? _____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			(PHYSICIAN'S NAME: _____)
21. HAS CHILD HAD: _____ BOILS, _____ CHICKENPOX, _____ ECZEMA, _____ GERMAN MEASLES, _____ MEASLES, _____ MUMPS, _____ SCARLET FEVER, _____ WHOOPING COUGH?			
22. HAS CHILD HAD: _____ HIVES, _____ POLIO?		*	
23. HAS CHILD HAD: _____ ASTHMA, _____ BLEEDING TENDENCIES, _____ DIABETES, _____ EPILEPSY, _____ HEART/BLOOD VESSEL DISEASE, _____ LIVER DISEASE, _____ RHEUMATIC FEVER, _____ SICKLE CELL DISEASE?		*	If "yes", transfer information to Forms 1 and 5.
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS (Rash, itching, swelling, difficulty breathing, sneezing)? a. WHEN EATING ANY FOODS? _____ b. WHEN TAKING ANY MEDICATION? _____ c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.?		*	If "yes", transfer information to Forms 1 and 5. WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. (If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:) DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

For use with Activity 6 in Module 1 (& Activity 9 in Module 2)

Appendix C: Blank Records & Forms

Handout C: Child Health Record Sample (Part 2)

CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT	CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____						
	HEAD START CENTER: _____			PHONE: _____			
	ADDRESS: _____						
	1. RELEVANT INFORMATION (from Health History, Parent/Teacher Observations):						
2. SCREENING TESTS. Starred Items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.							
TEST		DATE	RESULTS	TEST		DATE	RESULTS
a. PRESENT AGE*			____ Yrs., ____ Mos.	g. VISION (Type of Test)*			
b. HEIGHT (no shoes, to nearest 1/8 in.)*				ACUITY, R/L _____			
c. WEIGHT (light clothing to nearest 1/4 lb.)*				RESCREENING _____			
d. BLOOD PRESSURE				STRABISMUS _____			
e. HEMATOCRIT or HEMOGLOBIN*				COMMENTS _____			
f. HEARING (Type of Test)*				h. OTHER TESTS (if indicated)			
RESULTS, R/L _____				(1) TB _____			
RESCREENING _____				(2) Sickle Cell _____			
COMMENTS _____				(3) Lead _____			
				(4) Ova & Parasites _____			
				(5) Urinalysis _____			
				(6) Other _____			

Immunizations	Birth to 1 Month	2 Months	4 Months	6 Months	12-18 Months	4-6 Years
DIP						
Polio						
HIB						
HepB						
MMR						
Other			Note: Ages and number of boosters may vary when immunizations start at older ages.			

For use with Activity 6 in Module 1 (& Activity 9 in Module 2)

Appendix C: Blank Records & Forms

Handout C: Child Health Record Sample (Part 3)

CHILD HEALTH RECORD: FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: _____ DATE: _____ RELATIONSHIP: _____
 NAME OF INTERVIEWER: _____ TITLE: _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT
 THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____ NO, _____ YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____ NO, _____ YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____ NO, _____ YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. (INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).

	EARLIER	WHEN EXPECTED	LATER	AGE
a. WOULD YOU SAY YOUR CHILD BEGAN TO _____ EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?				
(a) SIT UP WITHOUT HELP				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

b. WHEN DID HE/SHE BEGIN TO _____?

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____ NO, _____ YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

 WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

For use with Activity 6 in Module 1 (& Activity 9 in Module 2)