Child's Name:_____ DOB: _____

Clover NOLA

CHILD'S HEALTH RECORD

Dear Parent/Guardian: The above named child and family was recently enrolled in our Head Start Program, a federally funded early childhood development program. We appreciate your assistance in completing this form.

General Information

Important Medical Conditions in Case of Emergency:

[ ] Asthma [ ] Seizure [ ] Diabetes [ ] Seizures [ ] Heart Condition [ ] Allergies : _____

[ ] Other:_____

Medications: _____

Pregnancy and Birth History

1. Any health problems during pregnancy or child birth? [ ] Yes [ ] No
   If yes, please explain: _____
2. Mother receive care throughout pregnancy? [ ] Yes [ ] No
3. Child born in hospital? [ ] Yes [ ] No
4. Was child born 3 weeks early or 3 weeks late? [ ] Yes [ ] No
5. Child stay in hospital longer than 3 days? [ ] Yes [ ] No
   If yes, please explain: _____

Hospitalizations and Illiness

1. Has Child ever been hospitalized? [ ] Yes [ ] No
2. Any surgeries? [ ] Yes [ ] No
   If yes, please explain: _____
3. Has Child ever had a serious accident or illness? [ ] Yes [ ]No
   If yes, please explain: _____

Health Problems

1. Does the child have frequent [ ] sore throat [ ] cough [ ] ear infections [ ] urinary infections [ ] stomach pain, nausea, vomiting, or diarrhea?
2. Does the child have difficulty seeing? [ ] Yes [ ]No Glasses: [ ] Yes [ ] No
3. Does the child frequently [ ] rub ears [ ] have earaches [ ] favors one ear [ ] ear discharge
4. Does the child scratch their behind while asleep [ ] Yes [ ] No
5. Has the child ever had a seizure/convulsion [ ] Yes [ ] No Medication: _____
6. Child currently on medication? Medications: _____
7. Has child had: [ ] hives [ ]boils [ ]chickenpox [ ]eczema [ ]mumps [ ]Scarlett fever [ ]measles [ ]whooping cough [ ] asthma [ ]epilepsy [ ]sickle cell [ ]rheumatic fever [ ]allergies [ ]polio [ ] liver disease [ ]disability
8. If the child has allergies: Type [ ] food [ ]medicine [ ]things
   List causes:_____ What happens? _____
9. Any health problems to add: _____

Child's Name:_____ DOB: _____

Physical, Psychological, and Social Development

1. Does your child take naps? [ ] yes [ ] no How long?_____ When? _____
2. Does your child have trouble sleeping 8 hours at night? _____
3. Can your child tell you when they have to use restroom? [ ] yes [ ] no
4. Is your child potty-trained? [ ] yes [ ] no
5. Does your child worry? [ ] yes [ ] no Explain: _____
6. Is your child afraid of anything [ ] yes [ ] no Explain: _____
7. How does your child play well with other children?
   Explain: _____
8. Does your child play with children their age? [ ] yes [ ] no
9. Can your child express what they want well? [ ] yes [ ] no
10. Any big changes for your child in the last 6 months such as:
    [ ] new relationship [ ] homelessness [ ] new home [ ] death [ ] trauma [ ] new sibling [ ] other

Please list the age your child started to do the following, if they have not write n/a:

(a) Sit up without help _____ (b) crawl _____ (c) walk _____ (d) talk_____

(e) feed and dress self _____ (f) use toilet _____ (g) respond to direction (h) play with toys

(i) use crayons _____ (j) understand what is said to them_____

Nutrition:

Does your child take vitamins [ ] yes [ ] no If yes, please list:_____

Any food restrictions (medical or religious)_____

Has your child's appetite changed? [ ] yes [ ] no Does your child take a bottle? [ ] yes [ ] no

Does your child have trouble swallowing or chewing? [ ]yes [ ] no If yes, please explain: _____

FORM 2A. HEALTH HISTORY

Child's Name:_____ DOB: _____

Dear Parent/Guardian:
Many children experience stressful life events that can affect their health and well-being. The results from this questionnaire will assist Kingsley House in assessing their health and determine guidance.
The information from this survey will remain confidential. Please answer honestly.

Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.

Please DO NOT mark or indicate the specific statements that apply to your child.

1) Of the statements in Section 1, How many apply to your child? Write the total here ☐

Section 1: At any point since your child was born….

- Your child's parents were separated or divorced
- Your child lived with someone who served time in prison
- Your child lived with someone who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members threaten or hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child
- Someone touched your child's private parts in a sexual way
- More than once your child went without food, clothing, a place to live, or had no one to protect her
- Someone pushed, grabbed, slapped or threw something at your child
- Your child lived with someone who had a problem with drinking or drugs
- Your child felt unsupported, unloved, or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number here ☐

Section 2. At any point since your child was born……

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was treated badly because of race, sexual orientation, place of birth, disability or religion

FORM 2D, ACE-Q, CHILDHOOD EXPERIENCES

Child's Name:_____ DOB: _____

Clover New Orleans

FOR MEDICAL PROVIDER

Dear Provider:

This child was recently enrolled in our head start program, a federally funded childhood development program. They mandate that all children are up to date on the Louisiana Early Periodic Screening, Diagnosis, and Treatment guidelines. We appreciate your assistance in completing this form.

Current Health

Date of **current** well child physical exam: _____ Due date for next well-child exam:_____

Chronic Conditions/Illnesses: _____

Current Medications Name and Dosage: _____

Will the medication be needed at school (8-5pm, M-F) [ ] yes [ ] no

If yes, please provide guardian with a medical plan for school to include (name, dose, strength, when to give, times to give, length of time, side effects, etc.) Medical plan provided [ ] yes [ ] no

Allergies: _____ Special Accommodations: _____

Health Assessment (*required screenings per Head Start program regulations)

Present age:_____ yrs _____ m.o. Height*: _____ Weight*:_____ Head Circ.* (0-2 y.o.)_____

Nutritional concerns (food allergies, over/under weight, nutritional anemia)? [ ] yes [ ]no

If yes, please explain: _____

Was an unclothed physical exam performed at this visit? [ ] yes [ ] no

If yes, were neuro, heart, lungs, abdomen, bones, genitalia, joints, and muscles normal? [ ] yes [ ] no

If no, please explain: _____

Test	Date	Results	Test	Date	Results
*Blood Pressure (due at 3 y.o. +)			*Hearing Screening (due at 3y.o & 4y.o.)		
*Hemoglobin/Hematocrit (due at 12 m.o & 2-3 y.o.)			*Vision Screening (due at 3 y.o & 4 y.o)		
*Newborn Sickle Cell			Anemia (due at 12 m.o.)		
*Blood Lead Level (due at 12 m.o & 2-3 y.o.)			Oral Health (due at 6 & 9 m.o.)		
*Developmental Screening (due at 9mo, 18mo, & 30 mo)			*Autism Screening (due at 18 m.o. & 2 y.o.)		

Health Visit Summary

Is the child up-to date on the Louisiana EPSDT Schedule? **[ ] yes [ ] no**

Is the child up-to-date on the Louisiana Immunization Schedule? **[ ] yes [ ] no**

Please attach a current and signed immunization record

Findings, Treatments, and Recommendations: _____

_____ _____

Provider Signature Date

Revision April 2023/crj

FORM 3A, PHYSICAL EXAM

Child's Name:_____ DOB: _____

Clover New Orleans

FOR DENTAL PROVIDER

Dear Provider,

This child is recently enrolled in our head start program, a federally funded childhood development program. They mandate that all children are up to date on the Louisiana Early Periodic Screening, Diagnosis, and Treatment guidelines. We appreciate your assistance in completing this form.

Current Health

Diagnostic and Preventive Procedures Performed:

❑ Clinical Examination ❑ Prophylaxis ❑ Other

❑ X-Rays ❑ Fluoride application

Current Status:

Cavities: (How Many) _____ Recurrent decay around old fillings: (How Many)_____

Gums and supporting tissues: ❑ Normal & Healthy ❑ Slight Inflammation (gingivitis)

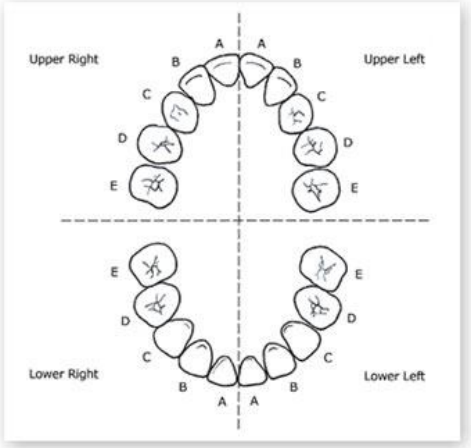
❑ Moderate Inflammation (gingivitis) ❑ Advanced disease (periodontitis)

Other: _____

Recommendation: (One selection is required)

❑ No further treatment recommended at this time. Return in _____ months for an examination.

❑ Additional dental treatment is required. Treatment plan is identified below.



Tooth Letter	Treatment Required

_____ _____

Dentist Signature Date

Form 4, Dental Health

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