Health History –Infants/Toddlers

Child's Name: _____

Required only for new enrollments 29 months and younger

Please check Y for **yes**, N for **no** for each question listed.
If **yes**, please describe in the space provided.

A. Health

Y N 1.Does your child seem well most of the time?

Y N 2. Is your child taking any medications now, at home or to be given at school (including aspirin, laxatives, vitamins, etc.)?

If YES, What? _____

How often? _____

(Note: Another form, including physician's signature is required for medications to be given at school)

Y N 3. In a year has your child had as many as three ear infections?

Y N 4. Are you concerned with your child's hearing?

Y N 5. In a year, does your child have more than three colds or sore throat infections with fever?

Y N 6. Are you concerned about your child's eyes or vision?

Y N 7. Has your child been seen by a medical specialist?

If YES, Who? _____

For What? _____

Last date seen by a specialist? _____

Y N 8. Does your child have any special needs?
If yes, please elaborate: _____

Y N 9. Other illness/diseases?
If yes, please list: _____

Y N 10. Has your child been hospitalized within the past year?
If yes, please describe: _____

Y N 11. Has your child had any serious accidents or poisonings?
If yes, please describe: _____

Y N 12. Does your child chew unusual things, such as pencils, chalk, crib, window ledges, paint chips, plaster, or hair?

13. Has your child had any of the following:

Y N Premature birth.
Y N Birth injury or defect
Y N Trouble breathing at birth
Y N Convulsions/seizures
Y N Allergies: (please circle) Eczema Hives Drug/food intolerance Hay Fever
Wheezing Asthma Insect stings Other:

If yes to any of the above, please describe including treatment.

B. Developmental History

14. How do you comfort your child?

15. What are your child's favorite toys?

What are your child's favorite activities?

15. What language is spoken in your home?

C. Sleeping

Y N 17. Do you have any special ways of helping your child to sleep?
Please describe:

Y N 18. Does your child cry when going to sleep?

What is your child's present sleeping schedule?

Nighttime: From _____ to _____

A.M. Nap: From _____ to _____

P.M. Nap: From _____ to _____

D. Feeding

19. Is your baby breast-fed? **Yes** or **No** Bottle-fed? **Yes** or **No**

*Type of bottle: _____ *Type of nipple _____

*Type of formula _____

How many ounces taken between burps?

(Note: Please provide two bottles for babies who are formula fed. Breastfeeding bottles will be sent back and forth daily. Please label all expressed milk with name date and time expressed.)

20. What is your child's present eating schedule (specify amount and time for milk/formula, juice, food)

Breakfast _____

A.M. Supplements _____

Lunch _____

P.M. Supplements _____

(Note: If your child is eating anything other than just milk/formula, please ask for an infant diet sheet and return it to your child's teacher. We like you to "try" new foods at home first, and then let us know that it's ok to feed these new foods to your child. Our chef makes baby foods in-house, please talk with your child's teacher to learn what foods are available and when).

Y N 21. Does your child have feeding problems?
Please describe:

E. Toileting

22. How frequently does your child have a bowel movement?

23. Appearance of BM:

Y N 24. Is your child toilet trained? If no, have you started working on training at all?

25. What word does your child use for:

Urination:

Bowel movement:

Y N 26. Do they use a potty chair? If yes, what style?

Y N 27.Does your child frequently have diaper rash? If yes, how would you like us to treat your child's diaper rash? Please provide your preferred diaper cream/ointment

*INFANTS ONLY

Parent's Signature: _____

Date: _____