Whispering Pines Programs for Young Children

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CHILD HEALTH ASSESSMENT

Student's Name: _____ Sex: ____ DOB: _____ School District: _____

Home Address: _____ _____ _____ NY _____ _____
Street address City/Town ZIP County

Father's Name: Last: _____ First: _____ Middle: _____

Address (if different): _____

Telephone: Home: _____ Cell: _____ Work: _____

Mother's Name: Last: _____ First: _____ Middle: _____

Address (if different): _____

Telephone: Home: _____ Cell: _____ Work: _____

Person with whom child lives, if other than parent:

Last: _____ First: _____ Relationship: _____

Telephone: Home: _____ Cell: _____ Work: _____

Primary Care Provider (physician, NP, PA): _____Phone: _____

When was your child's last physical exam: _____

Does your child have any allergies? ____ Yes ____ No If yes, please complete the box below

Allergy type	Reaction – list items and reactions	School restrictions or recommended actions (including prescribed medicine)
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

List ALL current medications here:

Please list any prescription and over the counter medication that your child takes on a regular basis.		
Medication Name and Dose	Time	Reason

Birth and Developmental History ____No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ____ Yes ____ No

Was infant born full term? ____ Yes ____ No How many weeks gestation? _____Did infant have any problems/illness at birth? ____ Yes ____ No

Briefly explain illness or problems.

_____

How does the child's development compare to other children, such as his or her brothers/sisters, cousins, or playmates?

____ About the same ____ Delayed ____ Advanced

Do you have any other concerns you would like to share?

_____

Do any health and/or medical conditions require school restrictions, modifications, and/or interventions?

____ Yes ____ No If YES, please explain:

_____

_____

_____

Does your child require any special procedures and/or treatments for their health condition(s)?

____ Yes ____ No If YES, please explain:

_____

Please indicate any other information about your child's health or development that you think would be helpful for the school to know:

_____

_____

_____

_____

Student Health Conditions

____Yes, my child receives regular medical/health care for the following conditions:			____ No medical conditions	
DATE			DATE	
Asthma/Wheezing			Hypoglycemia/Diabetes	
ADD/ADHD			Lead poisoning	
Autism Spectrum Disorders			Neuromuscular disorders	
Behavior Concerns: explain			Vision difficulties: corrective lenses, low vision/no vision	
Birth/Congenital defects - list			Bronchitis	
Bone/Muscle/Joint Problems			Croup	
Convulsions, Epilepsy, Seizures, Fainting			Pneumonia	
Cystic Fibrosis			Strep Infections	
Ear/hearing difficulties			Ear infections	
Headaches/Migraines			Whooping Cough	
Heart problems			Chicken Pox	
Hemophilia			Other:	

Is your child diagnosed with Asthma? If yes please complete the section below. If no, please go to the end of this form and sign. Thank you!

Asthma is a chronic condition that causes spasms of the bronchial tubes. It can cause persistent coughing, wheezing or shortness of breath. It is managed with medications. Inhaler medications provide relief and prevent an emergency. Please complete if your child has been diagnosed with Asthma or RAD (Reactive Airway Disease/Disorder). This will help us in creating a specific health care plan for your child—thanks.

Known Triggers: for this child's asthma (circle all that apply):

___colds ___mold ___exercise ___tree pollens
___dust ___strong odors ___grass ___flowers
___excitement ___weather changes ___animals ___smoke
___foods (specify): _____
___other (specify): _____

Activities: for which this child has needed special attention in the past (circle all that apply):

outdoors	*indoors*
___field trip to see animals	___kerosene/wood stove heated rooms
___running hard	___painting or renovations
___gardening	___art projects with chalk, glues
___jumping in leaves	___pet care
___outdoors on cold or windy days	___recent pesticide application
___playing in freshly cut grass	___sitting on carpets

other (specify): _____

Typical Signs and symptoms: of the child's asthma episodes (circle all that apply):

___fatigue
___breathing faster
___dark circles under the eyes
___flaring nostrils
___persistent coughing
___gray or blue lips or fingernails
___face red, pale or swollen
___wheezing
___sucking in chest/neck
___mouth open (panting)
___complaints of chest pain/tightness
___difficulty playing, eating, drinking, talking
___grunting
___restlessness
___agitation

other (specify): _____

Does your child use a nebulizer? ____ Yes ____ No
Does your child use an inhaler? ____ Yes ____ No
Does your child use a spacer with an inhaler? ____ Yes ____ No

Is there any other information you feel would help us understand the medical needs of your child better? _____

_____

_____

_____

_____

Seizure History: Has your child ever had a seizure? ____ Yes ____ No If yes please complete the questions below:

When was your child's last known seizure?_____How long did it last? _____ __

How often do the seizures occur?_____**I**f your child is on medications list in box on page 2

Describe the type of seizures your child has, if there is more than one type please describe below:

_____

_____

Does anything "trigger" your child's seizures? Please list all triggers:

_____

How long do they typically last?

How does your child act after the seizure?

Is there a history of seizures in the family? ____ Yes ____ No
Has your child experienced fever seizures? ____ Yes ____ No
Has your child been tested for lead exposure? ____ Yes ____ No

Is there any other information you feel would help us understand the medical needs of your child better?

Form completed by	Relationship to student	Date