Community Colleges of Spokane

SPOKANE COUNTY ECEAP
HEALTH, DENTAL AND DIET HISTORY

Reset Form

HEALTH HISTORY

Child's Name: _____ Sex: ☐ M ☐ F Birth date: _____

NAME OF CHILD'S HEALTH CARE PROVIDER: _____

DATE OF LAST WELL-CHILD EXAM: _____

Please answer the following:

1. Does your child have any of the following Health Concerns listed below?

- ☐ Asthma
- ☐ Anemia/Sickle Cell/Blood disease
- ☐ Bone/Orthopedic
- ☐ Bowel/bladder accidents
- ☐ Cancer
- ☐ Constipation/diarrhea/food intolerance
- ☐ Diabetes
- ☐ Eczema/skin condition
- ☐ Exposure to TB/respiratory disease
- ☐ Hearing/ear problems
- ☐ Heart trouble
- ☐ Neurological problems
- ☐ Seizures (with/without fever)
- ☐ Serious accidents/injuries
- ☐ Surgery/hospitalization
- ☐ Urinary tract infections
- ☐ Vision: (wears glasses/patch)
- ☐ Other: _____

Please explain any condition checked above: _____

2. Does your child have allergies or severe reactions to any of the items listed below?

- ☐ Animals
- ☐ Insect bites/bee stings
- ☐ Medications
- ☐ Food
- ☐ Latex
- ☐ Pollens/Hay Fever
- ☐ Other: _____

☐ Check here if any of the above conditions are LIFE THREATENING and explain the condition and/or the reaction. *(Staff: Please review individual Health Care Plan Policies & Procedures, additional action is required if marked)*

_____

3. Do you have any concerns about your child's health? If yes, please note below. ☐ Yes ☐ No

_____

4. Does your child take any medication (please list all medication, including vitamins)? ☐ Yes ☐ No

_____

5. Will your child need to be given any medications during ECEAP hours? ☐ Yes ☐ No

[Staff: Please review Medication Administration Procedures, additional action is required if marked YES]

If yes, what medication? _____

Parent/Guardian: Medication must be in the original container, labeled with the child's first and last name.

6. Does your child have special needs or need help to participate in classroom activities? ☐ Yes ☐ No

If yes, what? _____

DENTAL HISTORY

Date of last Dental Exam _____/_____/_____ ☐ My child does not have a dentist *[staff: Dental Referral]*

1. (*a*) Has your child ever had any cavities? ☐ Yes ☐ No

(*b*) If yes, have they been treated? ☐ Yes ☐ No

2. (*a*) Does your child brush his/her teeth daily? ☐ Yes ☐ No

(*b*) Do you help brush his/her teeth? ☐ Yes ☐ No

3. Do you have concerns about your child's teeth? ☐ Yes ☐ No

If yes, please explain _____

4. Do you have dental concerns for anyone in your family? ☐ Yes ☐ No

If yes, please explain _____

5. Is your child enrolled in the ABCD dental program? ☐ Yes ☐ No

(The Access to Baby and Child Dentistry Program for Medicaid eligible infants, toddler and preschoolers)

6. Would you like more information about the ABCD program? ☐ Yes ☐ No

7. Do you give your child systemic fluoride drops/tablets at home? ☐ Yes ☐ No

8. Does your family use fluoride toothpaste, gels and/or mouthwash at home? ☐ Yes ☐ No

DIET/NUTRITION HISTORY

1. Is your child currently on WIC? ☐ Yes ☐ No

If yes, which office? _____

2. Are there any foods your child may NOT eat for cultural, personal, ethnic or religious reasons? ☐ Yes ☐ No

If yes, please explain what foods _____

3. Are you satisfied with what your child eats? ☐ Yes ☐ No

4. Do you have any concerns about your child's weight or growth? ☐ Yes ☐ No

If yes, please explain _____

5. Does your child have any chewing or swallowing problems? ☐ Yes ☐ No

6. Does your child eat substances that are not commonly considered to be food (Pica)? ☐ Yes ☐ No

If yes, please explain _____

Parent/Guardian signature _____ Date _____

FSC signature _____ Date _____

Education staff signature _____ Date _____

Interpreter signature (when applicable) _____ Date _____

Nurse Consultant/HSS signature _____ Date _____

Updated Parent signature _____ Date _____