**HS Health/Nutrition Questionnaire**

(Please assure it is legible handwriting)

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS YOUR CHILD RECEIVING TREATMENT OR NEED TREATMENT BY A MEDICAL PROVIDER/SPECIALIST FOR A HEALTH CONDITION(S)? PELASE CHECK OFF DIAGNOSIS(S).**

* **Anemia**
* **Asthma**
* **Bowel/Bladder Problems**
* **Burns**
* **Diabetes**
* **Drugs or Alcohol during pregnancy**
* **Environmental Allergy**
* **Elevated Lead**
* **Exposure to Lead**
* **Exposure to Hepatitis**
* **Frequent Earaches/Infections**
* **Frequent Tonsillitis**
* **Hearing Problems**
* **Heart Murmur/Defects**
* **Medication Allergy**
* **Muscle/Bone Problems**
* **Recent Hospitalization/Surgery**
* **Reactive Airway Disease/Wheezing**
* **Seizure Disorders**
* **Serious Illness/Injury**
* **Tubes in Ears**
* **Vision Problems**
* **Wear Hearing Aids**
* **Other Serious Disorders**

IF YES OR HAS MULTIPLE CONDITION, LIST OTHER CONDITIONS HERE (complete release with practice name and child physician).

**DOES YOUR CHILD TAKE MEDICATION? Yes No**

If yes, please list medications

**WILL YOUR CHILD NEED TO TAKE MEDICATION DURING SCHOOL HOURS?**

Please list which medication? We do not administer Diastat at school (please contact health manager).

**DOES YOUR CHILD SUFFER FROM DIARRHEA, CONSTIPATION OR VOMITING FREQUENTLY?**

If yes, please explain

**WHAT LOCAL HOSPITAL DO YOU PREFER?**

**DOES YOUR CHILD HAVE OR AT RISK OR HAVING HIGH LEAD (rental property contains lead-based pant)?**

If yes, please explain

**HAS YOUR CHILD BEEN DIAGNOSED WITH A FOOD RELATED ALLERGY OR INTOLERANCE BY A DOCTOR?**

**YES** **NO**

If yes, what food and describe reaction your child has: we require a signed medical note by a doctor for any food or drink allergy. Dairy Milk restriction may require a parent signed note.

**ARE THERE ANY FOODS THAT YOUR CHILD MAY NOT EAT FOR CULTURAL OR PERSONAL BELIEFS/REASONS?**

**YES** **NO**

if yes, please explain, “Substitutions for non-medical reason will be approved on a case-by-case basis by the Nutrition Manager.”

**IS YOUR CHILD ON A DIET PRESCRIBED BY A DOCTOR?**  **YES** **NO**

 If yes, please explain

**DOES YOUR CHILD HAVE ANY CHOKING, CHEWING OR SWALLOWING CHALLENGES?**

**YES** **NO**

If yes, please explain

 **DOES YOUR CHILD CURRENTLY EAT NON-FOOD ITEMS?**

**IS YOR CHILD ON A DIET PRESRIBED BY A DOCTOR? Yes No**

If yes, please explain

**DOES YOUR CHILD CURRENTLY EAT NON-FOOD ITEMS? Yes NO**

**DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD’S EATING OR MEALTIME HABITS?**

 **YES** **NO**

 If yes, please explain

**DOES YOU FAMILY RECEIVE WIC? YES** **NO**

**IS YOUR CHILD’S IMMUNIZATIONS UP-TO-DATE?** Childcare licensing requires up-to-date immunizations with 30 days of enrollment. **YES** **NO**

**ARE YOUR CHILD’S IMMUNIZATION RECORDS IN THE STATE OF MAINE? YES**  **NO**

If No, where can we request records from?

**IS YOUR CHILD TOILET TRAINED? YES NO** **IN PROCESS**

If Yes or Almost, please answer; How do you want staff to support your efforts in toilet training while at school?

If No, a toilet training plan will be created at your first home visit with Promise staff.

**WILL YOUR CHILD REQUIRE DIAPER OR PULL-UPS? IF SO, WHAT SIZE?**

**IS THERE ANYTING ELSE YOU WOULD LIKE YOUR CHILD’S TEACHER OR HEALTH MANAGER TO KNOW**

**ABOUT YOUR CHILD?**

**The following questionnaire is to determine whether your child is at high risk for tuberculosis (TB) infection.**

**DID YOU, YOUR CHILD, OR ANYONE ELSE LIVING IN YOUR HOUSEHOLD COME TO THE UNITED STATES FROM ANOTHER CONTRY WITHIN THE LAST (3) YEARS THAT HAS A HIGH PREVELANCE OF TUBERCULOSIS i.e. Asia, Middle East, Africa, Latin America, Eastern Europe?** YES NO

**IF YES, DID YOU, YOUR CHILD, FAMILY MEMBER TRAVELING WITH YOU GET TESTED FOR TUBERCULOSIS UPON ENTERING THE U.S.?** If prior question was no, skip question.

**HAS YOUR CHILD HAD CLOSE CONTACT WITH ANYONE WITH AN ACTIVE INFECTIOUS TB DISEASE IN THE PAST 12 MONTHS?** YES NO

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| --- |
| **IS YOUR CHILD CURRENTLY BEING TREATED OR TAKING MEDICATION FOR TUBERCULOSIS?** YES NO  |
|  |

**WHAT HEALTH COVERAGE DO YOU HAVE FOR YOUR CHILD? MaineCare** **Private** **None**

MaineCare ID number is:

**TO KEEP YOUR CHILD SAFE AT SCHOOL PLEASE INFORM YOUR CHILD’S TEACHER/FAMILY ADVOCATE OF ANY CHANGES IN YOUR CHILD’S MEDICAL, NUTRITION OR DENTAL CONDITIONS WHILE ENROLLED AT PROMISE?**

 Parent understands and Agrees

Staff \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I will input all information into Child Plus before child is enrolled