**The Head Start Program of Androscoggin County**



269 Bates Street, Lewiston, ME 04240

**P:** (207) 795-4040 **F:** (207) 795-4044

**HS Health/Nutrition Questionnaire**

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

**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 restrictions.

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

YES NO

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

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

YES NO If yes, please explain

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

 If yes, please explain

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

 YES NO If yes, please explain

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

 YES NO

 If yes, please explain

**DOES YOU FAMILY RECEIVE WIC?**

YES NO

**IS YOUR CHILD RECEIVEING TREATMENT BY A MEDICAL SPECIALIST FOR ANY CONDITION BELOW?**

I.e. Pulmonologist, Ear Nose Throat specialist, Gastroenterologist, Neurologist, etc.

**Anemia Asthma Bowel/Bladder Problems Burns Diabetes Drugs or Alcohol during Pregnancy**

**Environmental Allergy 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 Disorder Serious Illness/Injury Tubes in Ears Vision Problems Wear Hearing Aids**

**Elevated Lead Other Serious Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None**

 If yes, please explain and list where we can request records from?

**DOES YOUR CHILD TAKE MEDICATIONS?** YESNO

Please list medication here.

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

**IS YOUR CHILD UP-TO-DATE WITH HIS/HER IMMUNIZAITONS?** 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?

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

YES NO

 If yes, please explain

**IS YOUR CHILD TOILET TRAINED?** YESNO IN PROCESS

How do you want staff to support your efforts in toilet training while at school?

Does your child require diaper or pull-ups? YESNO If yes, what size?

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

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

**HAS YOUR CHILD EVER HAD A POSITIVE TEST FOR TUBERCULOSIS?** YES NO

**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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|  **HAS YOUR CHILD TRAVELED TO A HIGH RISK COUNTY FOR MORE THAN 1 WEEK IN THE PAST TWO YEARS?**  YES NO \*High-risk country: Any country other than the United States, Canada,  Australia, New Zealand, or a country in Western or Northern Europe  |
|  |

**WHAT HEALTH COVERAGE DO YOU HAVE FOR YOUR CHILD?**

MaineCare Private NO Coverage

MaineCare ID number is:

**WHAT HOSPITAL DO YOU PREFER**?

**I HAVE BEEN TOLD THAT I AM RESPONSIBLE FOR INFORMING MY CHILD’S TEACHER/FAMILY ADVOCATE**

**OF ANY CHANGES IN MY CHILD’S MEDICAL, NUTRITION, OR DENTAL CONDITIONS WHILE ENROLLED AT PROMISE?** Yes, Parent was informed

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

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