MAHONING YOUNGSTOWN COMMUNITY ACTION PARTNERSHIP HEAD START/EARLY HEAD START

CHILD'S HEALTH & NUTRITION INFORMATION

Child's Last Name:	First Name:	D.O.B.	Sex: M ☐ F ☐
Parent/Guardian's Name:		Phone No.	
Address:	City:	Zip Code:	

Birth Verified: ☐ Y ☐ N (circle the verifying document) Birth Certificate Hospital Record Medical Card Medical Records Other: _____	Race: (circle all that apply) ☐Black (B) ☐Hispanic (H) ☐ White (W) ☐ Native Am. (N) ☐Pacific (P) ☐ Other:	
Medicaid Eligible: ☐ Y ☐ N Child's Billing Number:	Ins. Company/Managed Care Plan Ins. Number/MCP ID No.	Applied for Healthy Start: ☐ Y ☐ N Application Date:

I **Child is under the care of a physician**: ☐ **YES** ☐ **NO** **Date of last physical:** _____
Explain YES answers: _____

II **Child is under the care of a dentist**: ☐ **YES** ☐ **NO** **Date of last dental exam:** _____
Explain YES answers: _____

III **Has there been a big change in your child's appetite in the last month?** ☐ **YES** ☐ **NO**
Explain YES answers:
_____

IV **Is the child a picky eater?** ☐ **YES** ☐ **NO**

V **Chronic Physical Problems: (Check all conditions that apply-must match pg. 2 of application)**

☐ **Asthma**	☐ **Diabetes**	☐ **Seizure**	☐ **Heart Disease**	☐ **Liver Disease**
☐ **Loose Stools**	☐ **Constipation**	☐ **Low Birth Weight**	☐ **Baby Bottle Tooth Decay**	☐ **Frequent Bed Wetting**
☐ **High Lead**	☐ **Vision**	☐ **Hearing**	☐ **Difficulty Chewing**	☐ **Difficulty Swallowing**
☐ **Overweight**	☐ **Underweight**	☐ **Anemia**	☐ **Other – explain:** _____	

_____

VI **Is the child on WIC?** ☐ **YES - List Clinic:** _____
☐ **NO – If "NO" a referral must be made to WIC**
☐ **REFERRED**

VII **Has your child been tested for lead?** _____ **If so, when:** _____ **Where:** _____
Results: _____

VIII **Does the child have a disability or special need?** ☐ **YES** ☐ **NO** **Explain:** _____
_____

Transportation Code: ☐ Bus ☐ **Walking** ☐ **Parent** ☐ **Other:**	
Pick-up location:	**Drop-off location:**
Enrollment Comments:	

"Release To" Contacts:					
Name	Phone #	Rel.	Name	Phone #	Rel.
Name	Phone #	Rel.	Name	Phone #	Rel.

Signature of Parent/Guardian X	Date
Signature of Staff Member	Date

Distribution: White: Main File Yellow: Classroom Manual: Health REV.