MAHONING YOUNGSTOWN COMMUNITY ACTION PARTNERSHIP HEAD START/EARLY HEAD START

CHILD'S HEALTH INFORMATION

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

Birth Verified: ☐ Y ☐ N (circle the verifying document) Birth Certificate Hospital Record Medical Card Medical Records Other: ____________________	Race: (check 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 **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**
Overweigh	**Underweight] Anemia**		**Other – explain:** ____________	

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IV **Is the child on WIC?** **YES - List Clinic:** ____________________

NO – If "NO" a referral must be made to WIC

REFERRED

V **Has your child been tested for lead?** ____________ **If so, when:** ____________________

Where: ____________________ **Results:** ____________________

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

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Signature of Parent / Guardian **Date**

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