



CHILD HEALTH QUESTIONNAIRE

Child's name: _____ DOB: _____ Date of Form: _____

Does your child have any known allergies to any of the following:

- a. Food (milk, peanuts, eggs etc) _____
- b. Medicine _____
- c. Animals _____
- d. Bee / Wasp Sting _____
- e. Grass, Pollen, Dust _____

Describe the plan in place to respond if exposure to allergens should occur? _____

Does your child have Asthma? If yes, please also complete an Asthma Control Plan obtained from the Site Director (must be reviewed by Generations Health and Safety Director).

- What causes an attack? _____
- What is done to treat an attack? _____
- What can be done to prevent an attack? _____
- What activities have to be limited, if any? _____
- What medicine is given, if any? _____

Generations requires that the following routine screenings are done annually. Normally, your child's Health Care Provider will conduct these assessments. If not and you need a referral to someone who can provide them, please speak to the Site Director or Director of Health and Safety.

Does your child have any known speech / language difficulties? Yes _____ No _____
If yes, please explain: _____

Has your child received speech / language services? Yes _____ No _____
If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

Does your child have any known vision difficulties? Yes _____ No _____
If yes, please explain: _____

Has your child received services for impaired vision? Yes _____ No _____
If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

Does your child wear glass or contacts? No _____ Glasses _____ Contacts _____

Does your child have any known hearing difficulties? Yes _____ No _____
If yes, please explain: _____

Has your child received services for a hearing loss? Yes _____ No _____
If yes, by whom? When? _____

What was the date of the last screening? _____ Conducted by? _____

Does your child have any **dietary needs** we should be aware of? Yes _____ No _____
If yes, please explain: _____



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Has your child ever had an **eating or appetite problem**? Yes No
If yes, please explain: _____

Does your child tend to get a lot of **ear infections**? Yes No

Does your child take **medication** regularly? Yes No
If yes, what is the medication and how often is it taken? _____

(If medication is needed to be administered while at Generations, a medication form must be completed and updated regularly by the parent and health care provider.)

Has your child been hospitalized or seen in an emergency department? _____

It is expected that the child named on this form be immunized according to the Monroe County Department of Health schedule for immunizations. If the child is not yet fully immunized, please describe why and when the immunizations will be completed. (Children who have not yet reached school age should be immunized according to their age. Please respond only to immunizations that should have been completed to date.)

My child is fully immunized. Yes No
If not, reason immunizations have not been completed: Health Concerns
Religious Beliefs
Other: _____

Does your child have any other **“Special Health Needs”** that we should be aware of? Yes No
If yes, please complete the “Individual Health Care Plan for a Child with Special Health Care Needs”. (Obtain form from the Site Director.)

Has your child been tested for **lead**? Yes No
If yes, what was the date of the screening? _____
If not, Generations encourages a consultation with the child’s health care provider. Please log onto the Monroe County Health department at <http://www.monroecounty.gov/eh-leadpoisoning.php> for information. Additional information is available at the center.

In accordance with the HIPPA laws, your permission is required for Generations staff to have access to health information about your child. By signing this form, understand that Generations Administrative Staff and staff working directly with your child will have access to the information disclosed on this form and other pertinent information required to meet the daily needs of your child.

Parent/Guardian Signature: _____ Date: _____