5 SUPPLEMENTAL HEALTH HISTORY
YMCA OF NORTHERN COLORADO

Child's Name_____ Nickname _____

DOB _____ Birth Place _____

FAMILY MEMBERS RESIDING IN THE SAME HOUSEHOLD

1. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
2. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
3. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
4. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
5. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
6. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____

IMMEDIATE FAMILY MEMBERS RESIDING OUTSIDE THE HOUSEHOLD

1. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
2. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____
3. Name_____ Gender ☐ M ☐ F Birthdate_____ Relationship _____

PERSONAL HISTORY

Pets' names and types_____

What are your child's interests, activities, toys? _____

Has he/she had any other group experience? ☐ NO / ☐ YES If yes, explain:_____

Does he/she speak in words? ☐ NO / ☐ YES Complete Sentences? ☐ NO / ☐ YES

Any difficulty speaking? ☐ NO / ☐ YES If yes, explain: _____

Primary language used?_____ Other languages spoken?_____

Special Needs?_____

SOCIAL RELATIONSHIPS

Has your child had any experience playing with other children? _____

Briefly describe your child's personality (i.e. friendly, aggressive, shy) _____

Does your child like to be alone? _____ How does he/she relate to strangers?_____

Does your child demand a lot of adult attention? _____

What makes him/her upset? _____

How does your child show feelings? _____

What is the best way of handling your child?_____

Additional Information that would be helpful:_____

_____

_____

_____

6 SUPPLEMENTAL HEALTH HISTORY
YMCA OF NORTHERN COLORADO

GENERAL HEALTH HISTORY (If yes, please explain.)

Ever been hospitalized? ☐ NO / ☐ YES _____

Ever had surgery? ☐ NO / ☐ YES _____

Have recurrent/chronic illness? ☐ NO / ☐ YES _____

Ever had Measles? ☐ NO / ☐ YES _____

Ever Have Mumps? ☐ NO / ☐ YES _____

Ever have Rheumatic Fever? ☐ NO / ☐ YES _____

Ever have Chicken Pox? ☐ NO / ☐ YES _____

Ever have Scarlet Fever? ☐ NO / ☐ YES _____

Any medications given on a regular basis? ☐ NO / ☐ YES _____

Have allergies? ☐ NO / ☐ YES _____

Have asthma/wheezing/shortness of breath? ☐ NO / ☐ YES _____

Any physical disabilities? ☐ NO / ☐ YES _____

Have problems with falling asleep/sleepwalking? ☐ NO / ☐ YES _____

How many colds has your child had this past year? _____

How does your child react to elevated temperatures? _____

Additional information you feel helpful (special instructions if your child becomes ill, reactions to allergens, reactions to medications, etc.) :

_____

EATING HABITS (If yes, please explain.)

1. Is your child usually hungry at meal times? ☐ NO / ☐ YES _____

2. Between meals? ☐ NO / ☐ YES _____

3. Does your child use utensils? ☐ NO / ☐ YES

3. What are his/her favorite foods? _____

4. What foods are refused? _____

5. Any food allergies? ☐ NO / ☐ YES _____

Additional information you feel helpful: _____

TOILET HABITS

Can your child be relied upon to indicate his/her bathroom needs? ☐ NO / ☐ YES If no, explain: _____

What is the word used for urination? _____ Bowel movements? _____

Does your child need to go to the bathroom more frequently than normal for his/her age? ☐ NO / ☐ YES

Is he/she afraid of the bathroom? ☐ NO / ☐ YES If yes, explain: _____

Does your child need help in the bathroom? ☐ NO / ☐ YES If yes, explain: _____

When was toilet training started? _____ When accomplished? _____ Was your child ☐ easy or ☐ difficult to train?

Does your child wet the bed at night? ☐ NO / ☐ YES If yes, how often? _____

SLEEPING HABITS

What time does your child go to bed? _____ Awaken? _____ Does he/she have his/her own room? ☐ NO / ☐ YES Own bed? ☐ NO / ☐ YES

Does he/she walk or talk or cry during sleep? ☐ NO / ☐ YES If yes, explain: _____

What does he/she usually take to bed with him/her? _____

Does he/she take naps? ☐ NO / ☐ YES If yes, from when? _____ to _____

What is his/her mood upon awakening? _____

I understand that if the 2nd parent/legal guardian is not available to sign this form, I take full responsibility in informing him/her of all policies.

PARENT/LEGAL GUARDIAN Print Name: _____ Signature: _____ Date: _____

7 GENERAL HEALTH APPRAISAL
YMCA OF NORTHERN COLORADO

PARENT/GUARDIAN: Complete top section and give this form to your child's health-care provider for review.

Childs Name: _____ Gender _____ DOB: _____

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns.

My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school or camp.

Parent/Guardian Signature: _____ Date (authorization expires 365 days after this date): _____

HEALTH CARE PROVIDER

Please complete all remaining sections of this form. Attach additional information if needed. If physical exam is not completed during office visit please provide a signed copy of the most recent physical completed with in the last 12 months or per AAP Guidelines.

PHYSICAL EXAM

Physical exam completed today: ☐ YES / ☐ NO If no, date of last physical (mm/dd/yr.): _____ ☐ NORMAL / ☐ ABNORMAL

Weight (lbs): _____ Height (ft, in): _____ Blood Pressure: _____ Lead Level: _____

ALLERGIES/ASTHMA: ☐ None Known / ☐ Yes If yes, list foods, medications, environment, other: _____

_____

Symptoms which occur: _____

Recommended treatment: _____

Asthma Health Care Plan (list trigggers, medications, inhaler use): _____

_____

MEDICATIONS: ☐ No daily medications / ☐ Yes, will take the following medication(s) while at preschool (name, dose, frequency-describe below)

_____

_____

SIGNIFICANT HEALTH CONCERNS: ☐ None / ☐ Yes (Check and explain. If necessary, include instructions to childcare providers):

☐ Reactive Airways Disease ☐ Seizures ☐ Diabetes ☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Hospitalizations ☐ Severe Allergies

☐ Other (describe) _____

_____

MEDICAL TREATMENTS: ☐ None / ☐ Yes, the child is undergoing treatment at this time for the following condition (describe below)

_____

_____

IMMUNIZATIONS: ☐ Up-to-date / ☐ See attached immunization record / ☐ Administered today: _____

SPECIAL DIET: ☐ None / ☐ Yes, describe _____

RESTRICTIONS: ☐ No restrictions / ☐ Yes, the child will require limitations or restrictions to the following activities while at preschool (describe below)

_____

_____

Next Well Visit: ☐ Per AAP Guidelines or ☐ Age_____ This child is healthy and may participate in all routine activities, sports, camps and childcare. Any concerns or exceptions are identified on this form.

NAME OF LICENSED PROVIDER Print Name: _____ Signature: _____ Date: _____

Office Address: _____ Office Stamp:

Phone : _____