South
West
Early
Learning
Bilingual Preschool

SWEL Health History Form

Child's Name _____ Birth Date _____ Male_____ Female_____

Does your child have medical insurance? ☐ Yes ☐ No Dental insurance? ☐ Yes ☐ No

Name of Doctor/Clinic:_____ Phone: _____

Name of Dentist/Clinic:_____ Phone: _____

Date of last physical exam: _____ Date of last dental exam: _____

Who can you rely on for information and support about your child's health?

What do you want your child to know about being healthy?

What are your child special strengths and talents?

BIRTH AND DEVELOPMENTAL HISTORY

	Yes	No	If yes, please explain
Was your child more than 3 weeks premature or less than 5.5 pounds?			
Did the mother or baby experience complications during pregnancy or soon after birth?			
Has your child been assessed for, or received, any special developmental services? (speech, hearing, vision, physical, other)			
Do you believe your child needs any special developmental services (speech, hearing, vision, physical, other)			
Do you have any concerns regarding your child's: ☐ Sleep ☐ Behavior ☐ Toileting			

ALLERGY HISTORY

	List Specific Allergy Triggers	Reaction
Food ☐ **Yes** ☐ **No**		
Bee sting ☐ **Yes** ☐ **No**		
Medication ☐ **Yes** ☐ **No**		
Other: ☐ **Yes** ☐ **No**		

MEDICATION HISTORY

Does your child take any prescription medications ☐ Yes ☐ No

If yes, please complete the following:

Medication	Reason for Medication

HEALTH HISTORY

Does your child have :	Yes	No	If yes, please explain and give date of last Occurrence
Anemia			
Asthma			
Diabetes			
Eczema			
Heart Disease			
Seizures			
Bowel or bladder problems			
Ear Infections			
Pain in teeth or gums			
Pain in teeth or gums			
Recent hospitalizations or injuries			
Any health condition that limits climbing, walking or running			
Other			

ENVIRONMENTAL HEALTH ASSESSMENT

Do you have concerns about your child's exposure to:	Prenatal	Current	Comments
Pesticides or other chemicals			
Lead			
Medications or other Drugs			
Alcohol			
Smoke or Tobacco			

IDENTIFICATION OF NUTRITIONAL NEED

	Yes	No	Sometimes	Comments
Does anyone in your family receive WIC services? (Where?)				
Are there any foods your child may not eat for cultural or religious reasons?				
Does your child drink from a bottle?				
Do you ever not have enough food to feed your family?				
Do you have any concerns about your child's eating habits?				
Do you have any concerns about your child's weight or growth?				
How often does your child eat beef, chicken or fish?	Never	1 – 3 X /week	5 – 7 X/week	
How would you describe mealtimes at your house?				
What are your child's favorite activities?				
How much physical activity does your child get daily?				
How much screen time (TV, computer, game stations) does your child watch daily?				

HEALTH PROMOTION

	Yes	No
Does your child use a car seat/booster seat?		
Does your child use a helmet when riding tricycle, bike, scooter, etc...?		
Do you have a working smoke detector in your home?		
How often do your help your child brush his/her teeth?		

Is there anything else you'd like us to know about your child?

Parent/Guardian Signature_____**Date**_____

Reviewer's Signature _____**Date**_____