

Essential Records

BORN TO LEARN™ HEALTH RECORD

This is a 3-year form

Child's name _____ Birth date _____
 Parent/Guardian names _____ Birthweight _____ (lbs, oz)

Health History (Date completed) Year 1 _____ Year 2 _____ Year 3 _____

Age of child: Year 1 _____ Year 2 _____ Year 3 _____

Directions: For the following sections circle Y or N for each of the questions.

Was there difficulty during: Pregnancy Y N Labor Y N Delivery Y N

Did your child have any special conditions at birth (born early, jaundice, medical diagnosis, etc.)? Y N

If yes, what was it? _____

Does your child have a current medical condition? Y N Explain _____

Does your child have allergies? Y N If yes, to what? _____

	Year 1	Year 2	Year 3
Has your child had any illness with high fever? (104 F longer than 2 days)	Y N	Y N	Y N
Has your child had a serious illness or injury? If yes, Please explain.	Y N	Y N	Y N
Year 1: _____			
Year 2: _____			
Year 3: _____			
Does your child take medication regularly?			
Y N	Y N	Y N	
If yes, what medication(s)?			
Year 1: _____			
Year 2: _____			
Year 3: _____			
Does your child have regular medical check-ups?			
Y N	Y N	Y N	
If yes, from whom?			
Year 1: _____			
Year 2: _____			
Year 3: _____			
According to your healthcare provider, are your child's size and weight OK?	Y N	Y N	Y N
Do you feel you child eats a variety of nutritious foods?	Y N	Y N	Y N
Describe any concerns you have about your child's eating.			
Year 1: _____			
Year 2: _____			
Year 3: _____			
Has your child been screened for lead level? Results _____	Y N	Y N	Y N
Has your child been screened for anemia? Results _____	Y N	Y N	Y N

Safety

Directions: Answer each question for current year only.

Does your child ride in an approved car seat in the back seat?

• According to state laws: rear-facing safety seat in the back seat?

OR

forward-facing safety seat in the back seat?

If your child is involved in biking or skating, is a helmet used?

Year 1	Year 2	Year 3
Y N	Y N	Y N
Y N	Y N	Y N
Y N	Y N	Y N
Y N	Y N	Y N

General Development

Directions: To be completed by parent(s) or by parent(s) report.

What things can your child do very well?

Year 1: _____

Year 2: _____

Year 3: _____

What are some of the challenges you have with your child?

Year 1: _____

Year 2: _____

Year 3: _____

What concerns do you or someone else have about your child's general growth and development?

Year 1: _____

Year 2: _____

Year 3: _____

What concerns do you or someone else have about your child's behavior and does this affect their day today activities and relationships?

Year 1: _____

Year 2: _____

Year 3: _____

Sleep

Directions: Answer each question for current year only.

Does your child have a regular nap/bed time?

Year 1	Year 2	Year 3
Y N	Y N	Y N

How many hours does your child sleep per day?

_____	_____	_____
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Describe any concerns you have about your child's sleep?

Year 1: _____

Year 2: _____

Year 3: _____

Immunizations

Directions: Write date on each line or attach an immunization record copy. If family chooses not to immunize write NI.

	DTaP (DPT)	PCV	Influenza	Hib	IPV (Polio)	HepB	MMR	Varicella (Chicken Pox)
DOSE 1								
DOSE 2								
DOSE 3								
DOSE 4								
DOSE 5								

Key:

DTaP—Diphtheria, Tetanus, & Pertussis vaccines

PCV—Pneumococcal conjugate vaccine

Hib—Haemophilus influenzae type b vaccine

Varicella—Chicken Pox vaccine

IPV—Inactivated Poliovirus

HepB—Hepatitis B vaccine

MMR—Measles, Mumps, & Rubella vaccines

Adapted from: American Academy of Pediatric Recommended Childhood and Adolescent Schedule, June 2004.