List school district name here
 Parents as Teachers Missouri Curriculum Partner

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 **HEALTH RECORD FOR SCREENING EVENTS**

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| --- |
| **CHILD INFORMATION** |
| LAST NAME | FIRST NAME | MIDDLE NAME |
| DATE OF BIRTH | GENDER Male Female Non-binary Prefer Not to Report |
| Date Form Completed | child’s age |
| **PREGNANCY/LABOR/DELIVERY** |
| WAS THE PREGNANCY CONSIDERED HIGH RISK? Yes No | IF YES, PLEASE EXPLAIN  |
| WHAT WAS YOUR CHILD’S WEIGHT AT BIRTH? \_\_\_\_\_\_\_\_\_\_ LBS \_\_\_\_\_\_\_\_\_\_ OZ | HOW MANY WEEKS PREGNANT WERE YOU WHEN YOUR CHILD WAS BORN? |
| WAS THERE DIFFICULTY DURING PREGNANCY? Yes No | WAS THERE DIFFICULTY DURING LABOR? Yes No0 | WAS THERE DIFFICULTY DURING DELIVERY? Yes No0 |
| IF YES TO DIFFICULTY DURING PREGNANCY, LABOR, OR DELIVERY, PLEASE EXPLAIN |
| DID YOUR CHILD HAVE ANY SPECIAL CONDITIONS AT BIRTH (BORN EARLY, JAUNDICE, MEDICAL DIAGNOSIS, ETC.) OR STAY IN THE NICU? Yes No | IF YES, PLEASE EXPLAIN |
| IS THERE A POSSIBILITY THAT YOUR BABY WAS EXPOSED TO NEUROTOXINS BEFORE BIRTH (ALCOHOL, DRUGS, NICOTINE, OR PESTICIDES)? Yes No | IF YES, PLEASE EXPLAIN |
| **IMMUNIZATIONS** |
| Does your child receive immunizations? |  Yes No  |
| If yes, are they up-to-date per your child’s medical provider? |  Yes No  |
| If not currently up-to-date, are they in progress or are you using a delayed schedule with plans to catch up?  |  Yes No  |
| If no, is your family choosing not to immunize due to medical or religious reasons? |  Yes No  |
| Do you have or plan to obtain an exemption due to medical or religious reasons? |  Yes No  |
| **HEALTH REVIEW** |
| what type of health insurance is your child covered by? None Private MO HealthNet Other: |
| Does your child go to one place for regular medical check-ups and sick care? |  Yes No  |
| Doctor/nurse practitioner’s name | Date of last well visit? |
| HAS YOUR CHILD HAD A SERIOUS INJURY OR ILLNESS? Yes No | IF YES, PLEASE EXPLAIN |
| Has your child been diagnosed with any medical conditions (such as asthmas, reflux, allergies, etc.)?  Yes No  | IF YES, PLEASE EXPLAIN |
| Does your child take medication on a regular basis? Yes No  | IF YES, PLEASE EXPLAIN |
| Is your child exposed to second-hand smoke? |  Yes No  |
| **DENTAL** |
| How many teeth does your child have? |  |
| Does anything appear abnormal on your child’s teeth or gums (such as swelling, bleeding, sores, white/gray/brown spots on teeth or tiny holes, teeth growing in unusual places)?  Yes No | IF YES, PLEASE EXPLAIN |
| Is brushing teeth part of your child’s daily routine? Yes No | Do you floss your child’s teeth? Yes No |
| Have your child’s teeth been examined by a dentist?  Yes No | Does your child have cleanings twice a year? Yes No |
| Name of dentist | DATE OF MOST RECENT EXAM |
| Does your child fall asleep with a bottle or sippy cup?  Yes No | If yes, what does it contain?  |
| **HEARING** |
| DID YOUR CHILD HAVE A NEWBORN SCREENING? Yes No | IF YES, WHAT WERE THE RESULTS |
| does your child have a diagnosed hearing impairment? Yes No | IF YES, PLEASE EXPLAIN |
| hOW MANY EAR INFECTIONS HAS YOUR CHILD HAD IN THE LAST YEAR?  | IF NEEDED, HOW WERE EAR INFECTIONS TREATED (ANTIBIOTICS, TUBeS, OTHER)? |
| has your child had a hearing exam by a primary healthcare provider, hearing specialist, or someone else in the last 12 months?  |  Yes No  |
| IF YES, DATE | IF YES, WHO PERFORMED THE EXAM | IF YES, RESULTS OF THE EXAM |
| Do you or any of your child’s other caregivers have concerns with your child’s speech or language development, or have you noticed any regression in these areas?  Yes No  | IF YES, PLEASE EXPLAIN |
| For children under 2: do you or any of your child’s other caregivers have concerns about your child’s hearing (for example, not reacting to sudden loud noises, not turning toward interesting sounds or when their name is called, not imitating sounds, not using their voice to get attention, or not seeming to hear you if you talk in a whisper)? If yes, explain. Yes No | IF YES, PLEASE EXPLAIN |
| For children 2 and older: do you or any of your child’s other caregivers have concerns about your child’s hearing (such as seeming to have difficulty hearing, favoring one ear over the other, needing the TV volume up louder than other members of the family, not hearing you if you talk in a whisper, or making you talk loudly or repeat frequently)? If yes, explain. Yes No  | IF YES, PLEASE EXPLAIN |
| **VISION** |  |  |  |
| Does your child have a diagnosed vision impairment?  Yes No | If yes, explain |
| Has your child had a vision exam by a primary healthcare provider, vision specialist, or someone else in the last 12 months?  |  Yes No  |
| IF YES, DATE | IF YES, WHO PERFORMED THE EXAM | IF YES, RESULTS OF THE EXAM |
| Do you or any of your child’s other caregivers have concerns about your child’s vision, balance, or eye-hand coordination? Yes No | IF YES, EXPLAIN |
| Were any of your child’s biological parents or siblings prescribed glasses during childhood, or is there family history of “lazy eye” or eye disorders such as cataracts or refractive errors?  Yes No | IF YES, EXPLAIN |
| Has your child ever had an eye injury or an eye surgery?  Yes No | IF YES, EXPLAIN |
| Do either of your child’s eyes appear unusual? (For example, droopy eyelids, enlarged pupils or pupils of different sizes, encrusted eyelids, excessive blinking, frequent styes, sensitivity to light, watery eyes, jerky or repetitive eye movements, often rubbing eyes, reddened eyes/eyelids, white spots/cloudiness in the pupil).  Yes No | IF YES, EXPLAIN |
| Does your child have any difficulty walking or running due to tripping? Yes No | IF YES, EXPLAIN |
| For children 6 months and older: Does your child’s eye appear to turn in or out?  Yes No | IF YES, EXPLAIN |
| For children 6 months and older: Does your child turn or tilt their head, place objects close to look at them, or squint while looking at objects?  Yes No | IF YES, EXPLAIN |
| **FOR OFFICE USE ONLY** |
| HEARING SCREENING |  | VISION SCREENING |
| RESPONDS TO: | wHISPER | SQUEAK | BELL | RATTLE |  |  | ACUITY(3+ YEARS) | BLINK REFLEX (0-12 MO.) | PUPILLARY RESPONSE | CORNEAL LIGHT REFLEX | ALTERNATE COVER TEST | TRACKING |
|  | BOTH |  |
| RIGHT |  |  |  |  |  | RIGHT |  |  |  |  |  |  |
| LEFT |  |  |  |  |  | LEFT |  |  |  |  |  |  |
| Notes/results of other tools used (if available): |  | Notes/results of other tools used (if available): |