**POTOSI R-3 SCHOOL DISTRICT**
PARENTS AS TEACHERS MISSOURI CURRICULUM PARTNER

# HEALTH RECORD – MULTI YEAR

## CHILD INFORMATION

| LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| | | |

| DATE OF BIRTH | GENDER |
|---|---|
| | ☐ Male ☐ Female ☐ Non-binary ☐ Prefer Not to Report |

| OFFICE USE ONLY | INITIAL YEAR | YEAR 2 | YEAR 3 |
|---|---|---|---|
| DATE FORM COMPLETED/REVIEWED | | | |
| CHILD'S AGE | | | |

## PREGNANCY/LABOR/DELIVERY

| WAS THE PREGNANCY CONSIDERED HIGH RISK? | IF YES, PLEASE EXPLAIN |
|---|---|
| ☐ Yes ☐ No | |

| WHAT WAS YOUR CHILD'S WEIGHT AT BIRTH? | HOW MANY WEEKS PREGNANT WERE YOU WHEN YOUR CHILD WAS BORN? |
|---|---|
| _____ LBS _____ OZ | |

| WAS THERE DIFFICULTY DURING PREGNANCY? | WAS THERE DIFFICULTY DURING LABOR? | WAS THERE DIFFICULTY DURING DELIVERY? |
|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

| 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? | IF YES, PLEASE EXPLAIN |
|---|---|
| ☐ Yes ☐ No | |
| IS THERE A POSSIBILITY THAT YOUR BABY WAS EXPOSED TO NEUROTOXINS BEFORE BIRTH (ALCOHOL, DRUGS, NICOTINE, OR PESTICIDES)? | IF YES, PLEASE EXPLAIN |
| ☐ Yes ☐ No | |

## IMMUNIZATIONS

| | INITIAL YEAR | YEAR 2 | YEAR 3 |
|---|---|---|---|
| DOES YOUR CHILD RECEIVE IMMUNIZATIONS? | ☐ Yes ☐ No ☐ Exemption | ☐ Yes ☐ No ☐ Exemption | ☐ Yes ☐ No ☐ Exemption |
| IF YES, IS YOUR CHILD UP-TO-DATE PER THEIR MEDICAL PROVIDER OR ARE YOU USING A DELAYED SCHEDULE? | ☐ Up-To-Date ☐ Delayed | ☐ Up-To-Date ☐ Delayed | ☐ Up-To-Date ☐ Delayed |

## HEALTH REVIEW

| | INITIAL YEAR | YEAR 2 | YEAR 3 |
|---|---|---|---|
| IS YOUR CHILD COVERED BY HEALTH INSURANCE? IF YES, WHAT TYPE? | ☐ None ☐ Private ☐ MO HealthNet ☐ Other: | ☐ None ☐ Private ☐ MO HealthNet ☐ Other: | ☐ None ☐ Private ☐ MO HealthNet ☐ Other: |
| DOES YOUR CHILD GO TO ONE PLACE FOR REGULAR MEDICAL CHECK-UPS AND SICK CARE? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| DOCTOR/NURSE PRACTITIONER'S NAME | | | |
| DATE OF LAST WELL VISIT? | | | |
| HAS YOUR CHILD BEEN DIAGNOSED WITH ANY MEDICAL CONDITIONS (SUCH AS ASTHMAS, REFLUX, ALLERGIES, ETC.)? IF YES, PLEASE EXPLAIN. | ☐ Yes ☐ No Explanation: | ☐ Yes ☐ No Explanation: | ☐ Yes ☐ No Explanation: |
| DOES YOUR CHILD TAKE MEDICATION ON A REGULAR BASIS? IF YES, LIST NAME OF MEDICATION. | ☐ Yes ☐ No Medication: | ☐ Yes ☐ No Medication: | ☐ Yes ☐ No Medication: |
| IS YOUR CHILD EXPOSED TO SECOND-HAND SMOKE? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

## DENTAL

| | INITIAL YEAR | YEAR 2 | YEAR 3 |
|---|---|---|---|
| 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)? IF YES, DESCRIBE. | ☐ Yes ☐ No<br>Description: | ☐ Yes ☐ No<br>Description: | ☐ Yes ☐ No<br>Description: |
| IS BRUSHING TEETH PART OF YOUR CHILD'S DAILY ROUTINE? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| DO YOU FLOSS YOUR CHILD'S TEETH? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| HAVE YOUR CHILD'S TEETH BEEN EXAMINED BY A DENTIST? IF YES, LIST DATE OF MOST RECENT EXAM. | ☐ Yes ☐ No<br>Date: | ☐ Yes ☐ No<br>Date: | ☐ Yes ☐ No<br>Date: |
| NAME OF DENTIST | | | |
| DOES YOUR CHILD HAVE CLEANINGS TWICE A YEAR? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| DOES YOUR CHILD FALL ASLEEP WITH A BOTTLE OR SIPPY CUP? IF YES, WHAT DOES IT CONTAIN? | ☐ Yes ☐ No<br>Description: | ☐ Yes ☐ No<br>Description: | ☐ Yes ☐ No<br>Description: |

## HEARING

| | | | |
|---|---|---|---|
| DID YOUR CHILD HAVE A NEWBORN SCREENING?<br>☐ Yes ☐ No | IF YES, WHAT WERE THE RESULTS | | |
| | INITIAL YEAR | YEAR 2 | YEAR 3 |
| DOES YOUR CHILD HAVE A DIAGNOSED HEARING IMPAIRMENT? IF YES, EXPLAIN | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: |
| HAS YOUR CHILD HAD A HEARING EXAM BY A PRIMARY HEALTHCARE PROVIDER, HEARING SPECIALIST, OR SOMEONE ELSE IN THE LAST 12 MONTHS? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| IF YES, DATE OF HEARING EXAM | | | |
| IF YES, WHO PERFORMED THE EXAM | | | |
| IF YES, RESULTS OF THE EXAM | | | |
| HOW MANY EAR INFECTIONS HAS YOUR CHILD HAD IN THE LAST YEAR? IF NEEDED, HOW WERE EAR INFECTIONS TREATED (ANTIBIOTICS, TUBES, OTHER)? | Number:<br>Treatment: | Number:<br>Treatment: | Number:<br>Treatment: |
| <u>FOR CHILDREN UNDER 2</u>:<br>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 ☐ N/A<br>Explanation: | ☐ Yes ☐ No ☐ N/A<br>Explanation: | ☐ Yes ☐ No ☐ N/A<br>Explanation: |
| <u>FOR CHILDREN 2 AND OLDER</u>:<br>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 ☐ N/A<br>Explanation: | ☐ Yes ☐ No ☐ N/A<br>Explanation: | ☐ Yes ☐ No ☐ N/A<br>Explanation: |
| 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? IF YES, EXPLAIN. | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: |

| **HEARING SCREENING** | INITIAL DATE: | | YEAR 2 DATE: | | YEAR 3 DATE: | |
|---|---|---|---|---|---|---|
| CHILD'S AGE | | | | | | |
| NAME OF SCREENER | | | | | | |
| | **LEFT EAR** | **RIGHT EAR** | **LEFT EAR** | **RIGHT EAR** | **LEFT EAR** | **RIGHT EAR** |
| RESPOND TO WHISPER | | | | | | |
| RESPOND TO SQUEAK | | | | | | |
| RESPOND TO BELL | | | | | | |
| RESPOND TO RATTLE | | | | | | |
| OTHER (IF AVAILABLE): LIST TYPE | | | | | | |
| RESULTS | ☐ Pass ☐ Possible Concern | | ☐ Pass ☐ Possible Concern | | ☐ Pass ☐ Possible Concern | |
| FOLLOW UP/NOTES | | | | | | |

## VISION

| 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?<br>☐ Yes ☐ No | IF YES, EXPLAIN |
|---|---|

| | INITIAL YEAR | YEAR 2 | YEAR 3 |
|---|---|---|---|
| DOES YOUR CHILD HAVE A DIAGNOSED VISION IMPAIRMENT? IF YES, EXPLAIN. | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: |
| HAS YOUR CHILD HAD A VISION EXAM BY A PRIMARY HEALTHCARE PROVIDER, VISION SPECIALIST, OR SOMEONE ELSE IN THE LAST 12 MONTHS? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| IF YES, DATE OF VISION EXAM | | | |
| IF YES, WHO PERFORMED THE EXAM | | | |
| IF YES, RESULTS OF THE EXAM | | | |
| HAS YOUR CHILD EVER HAD AN EYE INJURY OR AN EYE SURGERY? IF YES, EXPLAIN. | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: |
| DO YOU OR ANY OF YOUR CHILD'S OTHER CAREGIVERS HAVE CONCERNS ABOUT YOUR CHILD'S VISION, BALANCE, OR EYE-HAND COORDINATION? IF YES, EXPLAIN. | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: |
| DOES YOUR CHILD HAVE ANY DIFFICULTY WALKING OR RUNNING DUE TO TRIPPING? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 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). IF YES, EXPLAIN. | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: | ☐ Yes ☐ No<br>Explanation: |
| FOR CHILDREN 6 MONTHS AND OLDER: DOES YOUR CHILD'S EYE APPEAR TO TURN IN OR OUT? IF YES, EXPLAIN | ☐ Yes ☐No ☐ N/A<br>Explanation: | ☐ Yes ☐No ☐N/A<br>Explanation: | ☐ Yes ☐No ☐N/A<br>Explanation: |
| 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? IF YES, EXPLAIN. | ☐ Yes ☐No ☐ N/A<br>Explanation: | ☐ Yes ☐No ☐N/A<br>Explanation: | ☐ Yes ☐No ☐N/A<br>Explanation: |

| **VISION SCREENING** | INITIAL DATE: | | YEAR 2 DATE: | | YEAR 3 DATE: | |
|---|---|---|---|---|---|---|
| CHILDS AGE | | | | | | |
| NAME OF SCREENER | | | | | | |
| | **LEFT EYE** | **RIGHT EYE** | **LEFT EYE** | **RIGHT EYE** | **LEFT EYE** | **RIGHT EYE** |
| BLINK REFLEX (0-12 MO.) | | | | | | |
| PUPILLARY RESPONSE | | | | | | |
| CORNEAL LIGHT REFLEX | | | | | | |
| ALTERNATE COVER TEST | | | | | | |
| TRACKING | | | | | | |
| ACUITY (AGES 3+) | | | | | | |
| | BOTH TOGETHER: | | BOTH TOGETHER: | | BOTH TOGETHER: | |
| RESULTS | ☐ Pass ☐ Possible Concern | | ☐ Pass ☐ Possible Concern | | ☐ Pass ☐ Possible Concern | |
| FOLLOW UP/NOTES | | | | | | |