ST. LOUIS PUBLIC SCHOOLS
Early Childhood/Early Childhood Special Education

DEVELOPMENTAL HEALTH & NUTRITION QUESTIONNAIRE

Child_____ **Date of Birth** _____ **Sex** ____ **Race** _____

Parent/Guardian _____ **Address** _____ **Zip** _____

Email _____ **Phone: (home)**_____ **(cell)** _____

Circle the letters "Y" for Yes or "N" for No to answer the following HEALTH HISTORY questions. If yes, please explain;			
Was your child born premature?	**Y**	**N**	**If yes, how far along was the pregnancy:**
Is your child's immunization record current?	**Y**	**N**	
Does your child have asthma?	**Y**	**N**	**If yes, submit Action Plan to nursing staff at school?**
Does your child have sickle cell disease or the trait?	**Y**	**N**	**If yes, which one?**
Does your child experience seizures?	**Y**	**N**	**If yes, explain.**
Does your child experience sinusitis, hay fever, dust allergies, eczema, etc.?	**Y**	**N**	**If yes, explain.**
Has your child had chicken pox, measles, mumps, scarlet fever, whooping cough or polio?	**Y**	**N**	**If yes, which one(s) and when?**
Do you or your pediatrician have concerns about your child's development and/or behavior?	**Y**	**N**	**If yes, whom and describe.**
Does your child have a disability or delay?	**Y**	**N**	**If yes, describe.**
Does your child have an IEP? If yes, is it for speech only?	**Y** **Y**	**N** **N**	
Does another family member have a disability or delay?	**Y**	**N**	
Has your child ever been hospitalized overnight?	**Y**	**N**	**If yes, when and why?**
Has your child had his/her 1st dental exam?	**Y**	**N**	**If yes, when/where?**

The following questions assess your child's risk for tuberculosis. Dates and results are required.	
What is the date of your child's last physical exam?	Date:
Has your child had a TB skin test read within 12 months?	No Yes Date: Result:
Has your child been in contact with any one of the following: someone with TB, homeless person, illegal drug user, group home resident, migrant worker, in prison within last 5 years, immigrants from Africa, Asia, Middle East or Latin America, an HIV-infected person?	No Yes

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Child _____ **Date of Birth** _____

The following questions are related to your child's OVERALL DEVELOPMENT. Please answer all questions.	
How old was your child when he/she started walking?	
Can your child climb stairs on his/her own?	
How old was your child when he/she said their first word?	
How old was your child when he/she started using two-three word sentences?	
Can you and others fully understand your child's speech?	
How old was your child when he/she first said their own name?	
Can your child tell others his/her full name?	
Can your child tell others his/her parent's full names?	
Does your child attend to his/her own toileting needs?	
How old was your child when he/she became toilet trained?	
How old was your child when he/she could put on a piece of their own clothing?	
What is your child's favorite thing to do?	
What is your child's least favorite thing to do?	
Name one thing that your child needs your assistance to complete?	

The following questions are related to your child's VISION.

Has your child ever had a vision exam or received treatment by an eye doctor? _____

If yes, when? _____ By whom? _____ Results: _____

Is there a history of vision concerns (vision loss, wears glasses, lazy eye, etc.) in the family?

If yes, explain what type: _____ Relationship to the child: _____

Circle the letters "Y" for Yes or "N" for No to the following questions.		
Do your child's eyes appear crossed or do not appear straight?	**Y**	**N**
Do your child's eyes appear to be in constant motion?	**Y**	**N**
Does your child experience redness, dry or watery eyes?	**Y**	**N**
Does your child experience frequent sties, encrusted or drooping eyelids?	**Y**	**N**
Does your child blink a lot?	**Y**	**N**
Does your child complain about headaches, itching, burning or pain in eyes?	**Y**	**N**
Is your child bothered by bright lights?	**Y**	**N**
Does your child stare into bright lights?	**Y**	**N**
Does your child appear unable to see distant objects, unless he/she moves head backward or forward?	**Y**	**N**
Does your child place object close to his/her eyes or squints to look at them?	**Y**	**N**
Does your child turn or tilt his/her head to the side or shows a preference for only one eye?	**Y**	**N**
Does your child appears clumsy or frequently bumps into furniture, walls, doorways, etc.?	**Y**	**N**
Is your child unable to stack blocks or other objects?	**Y**	**N**
Does your child only move an object by transferring it from one hand to the other?	**Y**	**N**

Thank you for completing page 2----------Please continue to Page 3

Child _____ **Date of Birth** _____

The following questions are related to your child's HEARING
Has your child had a hearing test or received treatment for hearing loss from a doctor, hospital or clinic? If yes, when: _____ By whom: _____ Results: _____
Has your child had an ear infection? _____ If yes, how many? _____ If yes, how was it treated? _____

Circle the letters "Y" for Yes or "N" for No to the following questions		
Is there a history of hearing loss in the family?	Y	N
Does your child use mainly one ear to listen?	Y	N
Is your child startled by sudden noises?	Y	N
Can your child hear a whisper?	Y	N
Do you have to speak loudly when talking to your child?	Y	N
Do you have to repeat words when talking with your child?	Y	N
Does your child need the TV turned up loud to hear?	Y	N

The following questions are related to your child and family's NUTRITION AND DIETARY HABITS			
How much did your child weigh at birth?			Birth weight ( ) pounds ( ) ounces
What is your child's current weight and height?			Height ( ) in. Weight ( ) lbs.
What is your child's favorite food?			
What food(s) does your child dislike?			
Has your child's doctor told you your child is anemic, diabetic, over/under weight or has food allergy?	**Y**	**N**	**If yes, please describe and provide a written statement from your child's pediatrician.**
Is there food that your child should not eat for cultural reasons?	**Y**	**N**	**If yes, which food(s)?**
Does your child take vitamins?	**Y**	**N**	**If yes, why?**
Does your child experience diarrhea or constipation regularly?	**Y**	**N**	
Does your child eat or chew on things that are not food?	**Y**	**N**	**If yes, describe?**
Has your child's appetite changed in the past month?	**Y**	**N**	**If yes, describe?**
Does your child have trouble chewing or swallowing?	**Y**	**N**	
Does your child have trouble feeding him/her self?	**Y**	**N**	
How old was your child when he/she was fed solid foods?			
At what age did your child start feeding him/her self?			
Does your child drink water every day?	**Y**	**N**	**If yes, how many glasses?**
Does your child drink milk every day?	**Y**	**N**	**If yes, how many glasses?**
Does your child drink soda, fruit drinks, Kool-Aid, etc.?	**Y**	**N**	**If yes, daily-weekly-monthly?** **How many glasses?**
Does your child eat at least three (3) meals per day?	**Y**	**N**	
Do you participate in the WIC program?	**Y**	**N**	
Do you participate in the Food Stamp (EBT) program?	**Y**	**N**	
Do you currently receive TANF?	**Y**	**N**	
Do you currently receive SSI/SSA?	**Y**	**N**	

If completed by an interpreter or other non-parent guardian, print your name and sign below:

Preparer's Signature _____ **Date** _____

Parent's Signature _____ **Date** _____

ST. LOUIS PUBLIC SCHOOLS

Early Childhood/Early Childhood Special Education

Communication Log

Child's Name _____ Parent's Name _____ Phone # _____

Center _____ Staff _____ Title _____

Documentation Guidelines: All entries must include the following information:

Date / Contact Code / Topic Code / Participants / Facts / Follow-Up Plan

First initial and last name must follow each contact entry on this page
Draw lines through any blank spaces after an entry is initialed

Date	Contact Code*	Topic Code**	SUMMARY OF CONTACT

***Contact code =** **(HV)** Home Visit**, (TC)** Telephone Call**, (CV)** Center Visit**, (NS)** No Show, **(C)** Cancelled, **(RE)** Rescheduled, **(OV)** Office Visit, **(L)** Letter

****Topic Code =**

(H) Housing
(F&N) Food & Nutrition
(T) Transportation
(HTH) Health
(SE) Social/Emotional
(I&B) Income & Budget
(F&P) Family Relationships/Parent Involvement
(CI) Community Involvement,
(AE&D) Adult Education & Development
(E) Employment
(SA&DV) Sexual Abuse & Domestic Violence
(SA) Substance Abuse
(R) Referrals
(D) Disabilities
(MH) Mental Health
(PTC) Parent Teacher Conference
(PIR) Program Information Report

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