Kirkwood Parents as Teachers Child Health Record

Child's name: _____ Date of birth:_____
Child identifies as: Male____ Female____ Other____ Prefer not to say_____
Parent Educator: _____
Pediatrician/Health Professional name: _____
Date completed: Year 1_____ Year 2_____ Year 3_____

PRENATAL/LABOR+DELIVERY/POSTPARTUM

Did you have any pregnancy-related diagnoses? For example, gestational diabetes or high blood pressure? ___Yes ___ No ___Unknown

How many weeks pregnant were you at delivery? _____

Child birthweight _____lbs _____oz

Child diagnosed with any medical conditions at birth? (i.e. jaundice)
___Yes ___ No ___Unknown

Child required a NICU stay after birth? ___Yes ___ No ___Unknown
If yes, was the stay 5 days or more? ___Yes ___ No ___Unknown

GENERAL HEALTH

Are your child's immunizations up to date?
Year 1 ___Yes ___ No ___Unknown Approximate Date:_____
Year 2 ___Yes ___ No ___Unknown Approximate Date:_____
Year 3 ___Yes ___ No ___Unknown Approximate Date:_____

Has your child been diagnosed with any medical conditions?
Year 1 ___Yes ___ No ___Unknown If yes, diagnosis:_____
Year 2 ___Yes ___ No ___Unknown If yes, diagnosis:_____
Year 3 ___Yes ___ No ___Unknown If yes, diagnosis:_____

Has your child been diagnosed with any allergies?
Year 1 ___Yes ___ No ___Unknown If yes, diagnosis:_____
Year 2 ___Yes ___ No ___Unknown If yes, diagnosis:_____
Year 3 ___Yes ___ No ___Unknown If yes, diagnosis:_____

GENERAL HEALTH CONTINUED

Has your child had any serious injuries that resulted in a hospital stay?
Year 1 ___Yes ___ No ___Unknown Reason:_____
Year 2 ___Yes ___ No ___Unknown Reason:_____
Year 3 ___Yes ___ No ___Unknown Reason:_____

Has a health care provider expressed concern over your child's size?
Year 1 ___Yes ___ No ___Unknown If yes,concerns:_____
Year 2 ___Yes ___ No ___Unknown If yes,concerns:_____
Year 3 ___Yes ___ No ___Unknown If yes,concerns:_____

Has your child been screened for Anemia?
Year 1 ___Yes ___ No ___Unknown If yes, results: _____
Year 2 ___Yes ___ No ___Unknown If yes, results: _____
Year 3 ___Yes ___ No ___Unknown If yes, results: _____

Has your child been screened for Lead?
Year 1 ___Yes ___ No ___Unknown If yes, results: _____
Year 2 ___Yes ___ No ___Unknown If yes, results: _____
Year 3 ___Yes ___ No ___Unknown If yes, results: _____

If your child has teeth, do you brush? If no teeth, do you clean their gums?
Year 1 ___Yes ___ No ___Unknown
Year 2 ___Yes ___ No ___Unknown
Year 3 ___Yes ___ No ___Unknown

SAFETY REVIEW

If your child is 12 months or younger, are they placed on their back to sleep?
___Yes ___ No ___Unknown

Is your child exposed to secondhand smoke?
Year 1 ___Yes ___ No ___Unknown
Year 2 ___Yes ___ No ___Unknown
Year 3 ___Yes ___ No ___Unknown

Parent Signature:_____ **Date:**_____