FOX C-6 SCHOOL DISTRICT
PARENTS AS TEACHERS MISSOURI CURRICULUM PARTNER

PARENT EDUCATOR: _____
PRIMARY LANGUAGE SPOKEN IN THE HOME: _____

HEALTH RECORD FOR SCREENING EVENTS

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 ☐ No	WAS THERE DIFFICULTY DURING DELIVERY? ☐ 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? ☐ 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, PLEASE EXPLAIN:	

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