Child Assessment Form

Purpose:

These questions are designed to give you the information needed to provide the best, most appropriate care for children. This information is confidential and parents must be reassured it will not be shared without their written permission.

Experts in the field recommend completing an assessment form for each child. It can help start mutual trust and respect that will develop into a strong, cooperative partnership between parents and caregivers.

The assessment should be completed prior to enrollment. Give parents an opportunity to review your enrollment forms and parent handbook before you complete the assessment form. The parent handbook or operational policies set forth your program's philosophy and values.

The enrollment interview is the time to obtain critical information about the child and provide information on your program's operational policies, such as health checks (if conducted), procedures for the release of children, and illness and exclusion criteria. It also provides parents an opportunity to assess your program and determine if it is best suited for their child's needs.

Child Assessment Form

Child Name (last, first, middle)		Enrollment Date	Date of Birth
Street Address (if rural, attach directions)	**City**	**County**	**Zip**
Mailing Address (if different) -- Street or P.O. Box	**City**	**County**	**Zip**
Telephone No. (include A/C)			

* If applicable.

1. Health

Does your child have any allergies?	☐ Yes	☐ No
If so, what allergies does your child have?		
How should we respond if he/she has an allergic reaction?		
Does your child have an existing illness?	☐ Yes	☐ No
Has your child had a previous serious illness or injury, or hospitalization during the past 12 months?	☐ Yes	☐ No
Is your child taking any medication?	☐ Yes	☐ No
If so, how is the medication administered, and will it need to be administered while he/she is in care?		
Is the medication prescribed for continuous use?	☐ Yes	☐ No
Are there any side effects we should be alerted to?	☐ Yes	☐ No

2. Toileting:

Does your child need assistance with toileting?	☐ Yes	☐ No
How can we best help?		
What are your ideas about toilet training?		
How can we best help?		

3. Behavior:

Does your child have any special fears?	☐ Yes	☐ No
How does your child communicate his/her needs?	☐ Yes	☐ No
Are there any special words that your child uses that might not be readily recognized?		
How do you tell your child to stop a behavior that you don't approve of or that might be dangerous?		
When your child gets upset, what helps him/her calm down?		
What is a good way to distract your child when he/she is having a temper tantrum?		
Are there any particular routines that are particularly helpful at naptime?		

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What position is most comfortable for your child when he/she is napping?	

4. Eating Preferences:

What are your child's favorite foods?		
Does your child use utensils, eat with fingers, feed self?		
Does your child choke easily while eating?	☐ Yes	☐ No

5. Activities:

What activities do you like to do with your child?	
What activities does your child like to do when playing with other children?	
What does your child like to do when he is playing alone?	

6. Family History:

Tell me about your family (i.e. child's parents, siblings, grandparents, and other extended family)	

I verify that the above assessment was discussed with the parent(s) of ______________________________

____

____

______________________________ ______________________________
Signature of Director Date Signed

I verify that the director appropriately relayed the information concerning my child's assessment.

______________________________ ______________________________
Signature of Parent Date Signed

Additional Comments:

"Texas law gives you the right to know what information is collected about you by means of a form you submit to a state government agency. You can receive and review this information, and request that incorrect information about you be corrected by contacting your licensing or child protective services representative."

MEDICAL HISTORY REPORT

Birth Parent's Name: ______________________________

Birth Child(rens) Name: ______________________________

MEDICAL HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES

Indicate by checking appropriate box if YOU or any of your RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, other children born to you, etc.) have had or now have the medical conditions listed below. Indicate person's relationship to you. Each birth parent must complete one of these forms for the child or children for whom you are relinquishing your parental rights. Please complete Comments Section. If a medical condition resulted in death of a family member, indicate this and the person's approximate age at time of death in Comments Sections.

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE (Specify Relationship)	COMMENTS
A. BIRTH DEFECTS					
1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.) Bilateral vs. uni-lateral.					
2. Cleft lip or cleft palate					
3. Down Syndrome					
4. Other chromosome abnormality Name, if known:					
5. Hydrocephalus					
6. Muscular dystrophy					Parts of body involved? Age at onset?
7. Dwarfism					
8. Spinal bifida					
9. Congenital heart defect					
10. Other (explain)					
B. ALLERGIES					
1. Eczema or other skin condition					Any cause known? What treatment? What medication?
2. Hay fever or other allergy					Any cause known? What treatment? What medication?
3. Drug allergy					To what drugs?
4. Food allergy					To what foods?
5. Other (explain)					
C. EYE, DENTAL, EAR,					
1. Blindness, glaucoma, color blindness or other visual problems					
2. Corrective glasses or contact lenses					At what age were prescription lenses necessary?
Nearsighted ☐ Farsighted ☐					
Astigmatism (inability to focus) ☐					
Strabismus (crosseye) ☐					
3. Braces on teeth or other orthodontia work					If so, what orthodontic work and for how long?

MEDICAL HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (...Continued)					
MEDICAL CONDITION	**NO**	**Not Known**	**YES Self**	**YES – RELATIVE** (Specify Relationship)	**COMMENTS**
4. Other dental problems					
5. Deafness or other ear problems Congenital vs. other					
D. DEVELOPMENTAL DISORDERS					
1. Speech problems					
2. Learning disability					Any diagnosis? Hospitalization?
3. Retardation: mental or physical					
4. Special education					Age at onset?
5. Other (explain)					
E. CIRCULATORY DISORDERS					
1. Hemophilia					
2. Sickle cell anemia or trait					Disease or carrier status?
3. Hypertension (high blood pressure)					Age at onset? What treatment? Hospitalization?
4. Stroke					Age at onset? What treatment? Hospitalization
5. Heart attack (coronary)					
6. Heart disease					Age at onset? What treatment? Hospitalization
7. Other (explain)					
F. HORMONAL DISORDERS					
1. Diabetes					Age at onset? What treatment?
2. Thyroid disorder					Age at onset? What treatment?
3. Obesity (overweight)					
4. Other (explain)					
G. RESPIRATORY DISORDERS					
1. Asthma					Any cause known? What treatment?
2. Emphysema					Age at onset?
3. Other (explain)					
H. MENTAL AND BEHAVIORAL DISORDERS					
1. Diagnosed schizophrenia					Age at onset? What treatment? Hospitalization?
2. Diagnosed Bi-polar					Age at onset? What treatment? Hospitalization?
3. Other mental illness. Describe, using additional page, if necessary					
4. Alcoholism or heavy drinking					
5. Drug usage, both legal & illegal					Kind, amount, and when taken?

MEDICAL HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (...Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE (Specify Relationship)	COMMENTS
I. LYMPHATIC DISORDERS					
1. Cancer					What kind? Age at onset? What part of body?
2. Tumors					What kind? Age at onset? What part of body?
3. Hodgkin's disease					
4. Other (explain)					
J. NERVOUS SYSTEM DISORDERS					
1. Multiple sclerosis					Parts of body involved? Age at onset?
2. Huntington's disease					
3. Cerebral palsy					
4. Seizures or convulsions (Epilepsy)					Age at onset? What treatment? Frequency?
5. Other (explain)					
K. INFECTION, HOSPITALIZATION					
1. Repeated attacks of fever with known infection					Diagnosis?
2. Repeated severe infection necessitating hospitalization					Age? Number of hospitalizations?
3. Hospitalization, operation, or injury					What for? When?
4. Tuberculosis					Age at onset? What kind? What part of body?
5. Other (explain)					
L. OTHER MEDICAL OR HEALTH PROBLEMS					
1. Arthritis					What kind? Age at onset? What part of body?
2. Kidney disease (renal)					Age at onset? What treatment?
3. Cystic fibrosis					What kind? Age at onset? What part of body?
4. Miscarriages					Number of pregnancies, number of live births
5. Alzheimer's					
6. Depression/Suicide					
7. Abuse/neglect					
8. Smoking					
9. Other					Please list premature deaths of close relative and other children born to you including age and cause of death.

Signature: ______________________________ ______________________________

Birth parent who completed this form — relationship to the child (birth mother or father)