Health Tracks Health History Form

Rolette County Public Health District
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Adapted from ND Department of Human Services/Department of Health SFN 1818 (Rev. 2-2011)

Public Health
Prevent. Promote. Protect.

Name:	Date of Birth:	Race:	Sex: ☐ M ☐ F
Mailing Address:	City:	State:	Zip Code:
Medicaid Number (if known):	Social Security Number (optional):	Telephone Number 1:	Telephone Number 2:
Information Provide by:	Name of Parent/Guardian:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Would be willing to accept text messages at following number:
Child in Foster Care: ☐ Yes ☐ No	Case Manager (if applicable):	Other Agency Involvement: ☐ WIC ☐ TANF	

Family Members of Child/People Living in Household

Name First	Last	(Maiden)	Sex	Marital Status	Relationship to Child	Date of Birth	Age

Child's Past Health History

Has Child Ever Had:	No	Yes	Comments	Has Child Ever Had:	No	Yes	Comments
Communicable Diseases (Hep C., Chicken pox, Measles, RSV, etc.)				Mental Health Disorders (Depression/Anxiety/PTSD/etc.)			
Convulsions/Seizures (other than febrile)				Skin Disorders (Dermatitis, Eczema, Rashes, Acne)			
Breathing Disorders/Asthma/ Inhaler or Nebulizer Use				Vision Disorders (Glasses, Surgery, Eye Patch, etc.)			
Seasonal Allergies (Hayfever)				Dental Surgery			
Multiple Ear Infections/Tube Placement				Surgery/Accidents/Serious Injuries/Fractures			
Learning Disabilities/ADHD/ADD				Other:			

Current Medications for Child

☐ Child Takes No Medications

☐ Child is Currently Taking Medications. List Medications _____

_____

☐ No known allergies ☐ Allergies (please list)_____

☐ Immunizations up to date. If not, list reason:_____

Child's Health Care Providers

Provider	Location	Date Last Seen
Doctor:		
Eye Doctor:		
Dentist:		
Orthodontist		
Specialist:		
Counselor:		

Child's Developmental Review

Does the child have trouble in any of the following areas NOW:

Sleeping	☐ Yes	☐ No	Isolation	☐ Yes	☐ No	Excessive Fears	☐ Yes	☐ No
Speech Problems	☐ Yes	☐ No	Frequently ill	☐ Yes	☐ No	Decision Making	☐ Yes	☐ No
Temper Tantrums	☐ Yes	☐ No	Bullying	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No	Nightmares	☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No

Is the child difficult to parent? ☐ No ☐ Yes – Explain:

Are there any other problems not mentioned above?

Are there any concerns about any of the following:

☐ Drinking Alcohol ☐ Drug Use ☐ School Performance ☐ Choice of Friends ☐ Mood/Attitude ☐ Peer Pressure ☐ Eating/Sleeping ☐ Harming Self (self-mutiliation) ☐ Sexual Activity ☐ Identity/Gender

Comments:_____

Have there been any changes in family dynamics?

☐ Separation/Divorce ☐ Recent move ☐ Loss of job ☐ Death of relative or close friend ☐ Gain of new family member

Was child born prematurely?

☐ No ☐ Yes. If yes, child was born how early? _____

If unable to be reached by phone, is there a number to leave a message for you to receive: _____-_____-_____

Child's School Information

What grade is the child currently in?

☐ Head Start ☐ Preschool ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

☐ GED courses ☐ College ☐ Alternative School Name of school_____

Is the child in any special classes (speech, reading, math) or have an IEP?

☐ No ☐ Yes, list:_____

Does the child take part in other activities (sports, music)?

☐ No ☐ Yes, list:_____

Have there been any changes in the child's school performance?

☐ No ☐ Yes, list:_____

Other comments/concerns related to school?

Is the child receiving services from:

☐ Anne Carlsen Center/Early Intervention ☐ Infant Tracking ☐ Peace Garden Consortium ☐ Right Tracks ☐ Other: _____

Summary/Additional Comments:

Consents

As parent/legal guardian/self, I hereby give my consent to release screening assessment information and to have him/her/myself undergo laboratory tests, examinations, and immunizations under the MCH/Health Tracks program for completion of the screening, diagnosis, and treatment and waive any legal action against any/all persons conducting the program. Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect participation in this program. Consent remains in effect for one year from date of signature.

Fluoride varnish helps to protect teeth from cavities. Fluoride varnish may be applied to my child's teeth 2-4 times per year. My child's teeth may look yellow for 24 hours after application. After receiving fluoride varnish, my child should not drink pop or have chips, candy, gum or other crunchy foods for one day. My child should wait until the next morning to brush their teeth and then can then resume normal oral hygiene. I understand that the oral screening my child receives is not a complete dental exam.

☐ Yes, I give permission for my child to participate in the fluoride varnish program

☐ No, I do not give permission for my child to participate in the fluoride varnish program.

Federal HIPAA Privacy Regulations are maintained by Rolette County Public Health District and Health Tracks Program Staff. Their Notice of Privacy Practices is available on site. I understand I may request a copy of RCPHD's Notice of Privacy Practices at any time.

Signature (parent/legal guardian/self):

X_____

Date: