

**Macomb Community Action Head Start 0-5  
Health History Update**

**Child's Name** (last, first): \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Does your child participate in **WIC**? Yes \_\_\_\_\_ No \_\_\_\_\_

What health insurance does your child have: \_\_\_\_\_

What dental insurance does your child have: \_\_\_\_\_

**Child's Doctor:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Office Name: \_\_\_\_\_ City: \_\_\_\_\_

Are there **ANY HEALTH** concerns your child's teacher should be aware of (examples include asthma, seizures, eczema) Yes: \_\_\_\_\_ No: \_\_\_\_\_

**If YES**, please explain:

\_\_\_\_\_

Does your child have any Doctor Diagnosed **Food Allergies**? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**If YES**, please explain:

\_\_\_\_\_

Will your child **require any medication** in the classroom: Yes: \_\_\_\_\_ No: \_\_\_\_\_

**If YES**, please explain:

\_\_\_\_\_

**Current Dental Information:**

**Dentist Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Office Name: \_\_\_\_\_ City: \_\_\_\_\_

**Parent Name:** \_\_\_\_\_

**Staff Member who reviewed with Parent:** \_\_\_\_\_

**Date of review:** \_\_\_\_\_