Referred by: parent ___; physician ___; school ___; Babies First ___; CaCoon ___; Other ___

Time to complete form ___
Referred to RN ___

HEALTH SCREENING QUESTIONNAIRE FOR EI/ECSE

Dear Parent or Guardian: The information on this questionnaire will help us to know whether your child's health is affecting development and will help us plan for educational services. (Provide details for any YES answers.)

Child's Name: ______________________ DOB: __________ County: ______________
Date Completed: ______________ Person Completing the form: ______________________
Primary Language: ______________ Relationship to Child: ______________________
Reason for Referral to EI/ECSE: ______________________________________

1a. Yes ☐ No ☐ Were there any complications during pregnancy, labor or delivery?
If yes, explain: ______________________________________

1b. Yes ☐ No ☐ Did your child have serious difficulties at birth?
If yes, explain: ______________________________________

2a. Yes ☐ No ☐ Do you have concerns about your child's nutrition or growth?
If yes, explain: ______________________________________

2b. Yes ☐ No ☐ Is your child on a special diet?
If yes, specify: ______________________________________

2c. Yes ☐ No ☐ Does your child have difficulties with feeding (such as choking, gagging, coughing, vomiting, slow to complete a meal)?
If yes, specify: ______________________________________

2d. Yes ☐ No ☐ Does your child require special feeding techniques (such as adapted utensils, special positions?
If yes, specify: ______________________________________

3. Yes ☐ No ☐ Does your child have a history of neurologic problems (such as seizures/epilepsy, muscle weakness, hydrochephalus or cerebral palsy)?
If yes, explain: ______________________________________

4. Yes ☐ No ☐ Does your child have an orthopedic problem (such as scoliosis, hand or foot deformity, hip dislocation)?
If yes, specify: ______________________________________

5. Yes ☐ No ☐ Does your child have any birth defects or genetic problem (such as cleft palate, heart defect or Down Syndrome)?
If yes, specify: ______________________________________

6a. Yes ☐ No ☐ Does your child have a history of chronic illness (such as diabetes, asthma or kidney problem)?
If yes, specify: ______________________________________

6b. Yes ☐ No ☐ Has your child been hospitalized, had surgery or a serious injury?
If yes, explain: ______________________________________

7a. Yes No ☐ ☐ Do you have any concerns about your child's hearing?
If yes, explain: ____________________

7b. Yes No ☐ ☐ Has your child's hearing been tested?
If yes, please specify where, when and what were the results: ____________________

7c. Yes No ☐ ☐ Does your child have a history of frequent or chronic ear infection, or tubes in ears?
If yes, specify: ____________________

8. Yes No ☐ ☐ Does your child have vision problems or wear glasses?
If yes, specify: ____________________

9a. Yes No ☐ ☐ Does your child use adaptive equipment such as wheelchair, prone stander, braces?
If yes, specify: ____________________

9b. Yes No ☐ ☐ Does your child need any other health treatments daily (such as gastrostomy feedings, intermittent catheterization)?
If yes, specify: ____________________

9c. Yes No ☐ ☐ Do any of these treatments need to be done at school?
If yes, specify: ____________________

10a. Yes No ☐ ☐ Does your child take medication every day?
If yes, list the medication(s) and note any side effects of the medication or what school staff should be made aware of: ____________________

10b. Yes No ☐ ☐ Does your child need to receive the medication at school?
If yes, specify: ____________________

11. Yes No ☐ ☐ Does your child have any allergies to medications, food or other substances?
If yes, specify and describe the symptoms and any treatment that is needed: ____________________
____

12. Yes No ☐ ☐ Do you have any other concerns about your child's health?
If yes, explain: ____________________

13a. Who is your child's primary health care provider (physician, nurse practitioner, health clinic, etc)?
Name: ____________________
Address: ____________________

13b. Pertaining to children age 3 or older. Who is your dentist?
Name: ____________________
Address: ____________________

Your child will have to meet immunization requirements (either documentation of having received specific immunizations, or an exemption for religious or medical reasons) to attend school (including day care or preschool) in Oregon. Be prepared to provide this information to whatever program in which your child is enrolled.