**EI/ECSE HEALTH SCREENING CHECKLIST**

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 early intervention services.

(Provide details for any YES answers.)

Child's Name: DOB: Contractor

Date Completed: Person Completing:

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 any serious difficulties at birth?

 🞏 🞏 If yes, explain

2a. Yes No Do you have any concerns about your child's nutrition or growth?

 🞏 🞏 If yes, explain

2b. Yes No Is your child on a special diet?

 🞏 🞏 If yes, explain

2c. Yes No Does your child have difficulties with feeding (such as choking, gagging,

 🞏 🞏 coughing, vomiting, slow to complete a meal)?

 If yes, explain

2d. Yes No Does your child require special feeding techniques (such as adapted utensils,

 🞏 🞏 special positions)?

3. Yes No Does your child have a history of neurologic problems (such as seizures?

 🞏 🞏 epilepsy, muscle weakness, hydrocephalus 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, explain

5. Yes No Does your child have any birth defect or genetic problem (such as cleft

 🞏 🞏 palate, heart defect or Down Syndrome)?

 If yes, explain

6a. Yes No Does your child have a history of chronic illness (such as diabetes,

 🞏 🞏 asthma or kidney problem)?

 If yes, explain

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 infections or

 🞏 🞏 tubes in ears?

8. Yes No Does your child have vision problems or wear glasses?

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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, explain

9c. Yes No Do any of these treatments need to be done at school?

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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

10b. Yes No Does your child need to receive the medication at school?

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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

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