**

***Olympic Educational Service District 114***

105 National Avenue North, Bremerton, Washington 98312

(360) 478-6887  1-800-201-1300  FAX (360) 405-5808

**WELLNESS ASSESSMENT**

Date Completed: Click or tap to enter a date.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Child’s Name: Click or tap here to enter text. | | | | | Date of Birth: | Click or tap to enter a date. | |
| Medical Insurance: Click or tap here to enter text. | | | | | Primary Care Provider:Click or tap here to enter text. | | |
| Dental Insurance: Click or tap here to enter text. | | | | | Dental Provider: Click or tap here to enter text. | | |
| Date of last Well Child Exam: Click or tap to enter a date. | | |  |  | Date of last Denta dsfs Date of Last Dental Exam:  Click or tap to enter a date. | | |
| Up-to-Date on Immunizations? | | | Choose an item. |  | Other Specialists: Click or tap here to enter text. | | |
| **PLANNING QUESTIONS** | | | | | | | |
| Choose an item. | | Does your child have a life threatening health condition (i.e. diabetes, asthma, allergies, seizures,) or special health care concerns? If **YES**, please explain: Click or tap here to enter text. | | | | | |
|  | | | | | | | |
|  |  | If yes, would medication be necessary in the classroom/center? | | | | Choose an item. | |
| If yes, what type/dose? Click or tap here to enter text. | | | | | | | |
| Choose an item. | | Does your child take any medications on a regular basis? | | | |  |  |
|  |  | If yes, would this medication be necessary in a 72-hour emergency? | | | | Choose an item. | |
| If yes, what type/dose? Click or tap here to enter text. | | | | | | | |
| Choose an item. | | Are there any foods your child cannot eat for medical, cultural or religious reasons? | | | | | |
|  |  | If yes, please list: Click or tap here to enter text. | | | | | |
|  |  |  |  |  |  |  |  |
| Were there any health concerns during pregnancy? If **YES**, please explain: Click or tap here to enter text. | | | | | | | |
| Were there special conditions at birth *(born early, health concerns, medical diagnosis, difficulty sucking/eating, etc.)*? | | | | | | | |
| If **YES**, please explain: Click or tap here to enter text. | | | | | | | |
| Do you have any concerns about your child’s growth or development? If **YES**, please explain: Click or tap here to enter text. | | | | | | | |
| Do you have any concerns about your child’s vision? If **YES**, please explain: Click or tap here to enter text. | | | | | | | |
| Do you have any concerns about your child’s hearing? If **YES**, please explain: Click or tap here to enter text. | | | | | | | |
| Do you have any questions or concerns about your child’s oral health? If **YES**, please explain: Click or tap here to enter text. | | | | | | | |
| Talk about mealtimes. What are your child’s favorite foods? What makes mealtime enjoyable, challenging? Click or tap here to enter text. | | | | | | | |
| Who is your support system? Click or tap here to enter text. | | | | | | | |
| Would you or anyone in your family like safety information about car seats and/or road safety for children?  Click or tap here to enter text. | | | | | | | |
| Do you or anyone in your family want information about substance abuse and treatment (tobacco, alcohol, drugs)?  Click or tap here to enter text. | | | | | | | |

*Wellness Assessment August 2020*