® Mississippi Action for Progress, Inc.

Comprehensive Folder

Early and Head Start

- **MAP Health record checklist**
- **Authorization for use and disclosures of your records**
- **Child health record form 1**
- **Insurance card**
- **Medical home information**
- **Child heath record form 2a**
- **Parent authorization for medical services**
- **Parent authorization for dental services**
- **Consent for child's emergency medical treatment**
- **Consent for child's emergency dental/medical treatment**
- **Child health record form 4**
- **Child's dental health history**
- **Child health record form 5**
- **Dental heath record**
- **Result of Screening**
- **Child health record form 6**
- **Growth charts**
- **Teacher's mental Health Observation checklist**

MAP HEALTH RECORD CHECKLIST

This record should contain:

___	___	___	1. Health Insurance Portability Accountability Act (HIPPA)
___	___	___	2. General Information (Form 1)
___	___	___	3. Medicaid/Insurance Card
___	___	___	4. Medical Home Information Form
___	___	___	5. Health History (Form 2A & 2B)
___	___	___	6. Parent/Guardian Permission to Reveal Confidential Information (as needed)
___	___	___	7. Parent Authorization for Medical Services
___	___	___	8. Parent Authorization for Dental Services
___	___	___	9. Consent for Child's Emergency Medical/Dental Treatment
___	___	___	10. Denial of Consent for Dental/Medical Services
___	___	___	11. Screenings/Physical Examinations (Form 3)
___	___	___	12. Immunization (Form 4)
___	___	___	13. Dental Health History
___	___	___	14. Dental Health (Form 5)
___	___	___	15.Dental Heath Record
___	___	___	16. Dental Follow-up Plan/Authorization for Treatment
___	___	___	17. Results of Screening
___	___	___	18. Nutrition (Form 6)
___	___	___	19. Follow-up Plan for Nutrition (as needed)
___	___	___	20. Height/Weight Charts
___	___	___	21. Psychological and Social Emotional Assessment (Form 9)
___	___	___	22. Teacher Mental Health Observation Checklist
___	___	___	23. Staff Observation of Health & Behavior (Form 10)
___	___	___	24. Parent Consent for Speech/Language and/or Hearing Evaluation (as needed)
___	___	___	25. Identifying & Diagnosing Children with Disabilities- Eligibility Report (as needed)
___	___	___	26. Individualized Education Program (IEP)/Individualized Family Services Plan (IFSP)
___	___	___	27. Evaluation/Assessment Report (as needed)

OBSERVER **DATE**

OBSERVER **DATE**

OBSERVER **DATE**

MISSISSIPPI ACTION FOR PROGRESS, INC.

1751 Morson Road
Jackson, Mississippi 39209

Phone: (601) 923-4100 Fax (601) 923-4157

AUTHORIZATION FOR USE AND DISCLOSURES OF YOUR RECORDS

During this school year, medical, health and disability/mental health information about your child will be collected. This information may include, but is not limited to: observations of classroom behavior rating scales, child development screening and evaluations, speech, language and hearing evaluations, dental examinations and health physicals. This information will be collected and placed in your child's school folder (file). By signing below you authorize MAP, Inc. and its medical, dental, disability/mental health, speech and hearing consultants and their professional staff to collect this information and use your child's records as necessary for determining how to best meet your child's health, mental health and academic needs.

You also authorize the disclosure of your child's medical, dental, health and mental health information and records obtained by MAP, Inc. and its associated professional consultants to teachers, relevant program staff, and MAP, Inc. health and mental health consultants. The reason for disclosure of your child's information is to facilitate the ability of MAP, Inc. to provide appropriate academic and health care services for your child. Your child's medical/mental health information and records, once disclosed, may be re-disclosed by any of the recipients identified above and may no longer be protected by the Privacy Standards of the Health Insurance Portability and Accountability Act (HIPAA), which is a federal regulation designed to protect medical information.

You have the right to revoke (cancel) this authorization at any time by providing MAP, Inc. with a written request. If you cancel this authorization, medical information and records about your child that were created before the authorization was cancelled will still be used and disclosed as needed.

This authorization will expire on Month_____ Day_____ Year_____. If you do not sign this authorization your child will not be allowed to receive health (medical, dental, disabilities/mental health, speech or hearing) services.

I hereby authorize the use or disclosure of my Protective Health Information. I understand that the information I authorize MAP, Inc. to receive may be re-disclosed and no longer is protected by Federal Privacy Regulations.

Child's Name (Please Print)	**Name of Child's Parent or Legally Authorized Representative (Please Print)**
Signature of Parent or Child's Legally Authorized Representative	**Date**

White Copy – Child's Folder
Yellow Copy – Parent's Copy
Pink Copy – Center Administrator

CHILD HEALTH RECO[illegible] — F[illegible]M 1, GENERAL INFORMATION

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

NAME OF INTERVIEWER:_____ TITLE:_____

1. PERSON INTERVIEWED_____
   DATE_____, RELATIONSHIP TO CHILD_____
2. CHILD'S NICKNAME, IF ANY_____
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   _____
   _____ Zip Code _____
   PHONE _____
4. FATHER'S NAME_____
5. MOTHER'S NAME_____
6. GUARDIAN'S NAME_____
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   _____
   PHONE_____, RELATIONSHIP_____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   _____English _____Spanish
   _____Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES NO EPSDT/Medicaid (Latest certification No.):
   _____
   YES NO Federal, State or Local Agency:
   _____
   YES NO In-Kind Provider:_____
   YES NO Other (3rd party):_____
   ID NO.:_____
   YES NO WIC
   YES NO Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    _____
11. DATE OF LAST VISIT TO DENTIST
    _____

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE
    (Name, address, and phone no.):
    Physician _____
    _____
    Clinic _____
    _____
    Hospital ER_____
    _____
    Other _____
    _____
    Dentist _____
    _____
13. IN CASE OF EMERGENCY NOTIFY
    (1) _____
    Relationship _____
    Phone _____ or _____
    (2) _____
    Relationship _____
    Phone _____ or _____
    (3) _____
    Relationship _____
    Phone _____ or _____
14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites_____
    - ☐ Allergy, Medication_____
    - ☐ Other_____

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER				
MOTHER				
BROTHERS & SISTERS *(oldest first)*				
(1)				
(2)				
(3)				
OTHER *(Specify relationship)*				
(1)				
(2)				
(3)				

(Use additional page if needed)

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

INTERVIEWER: GO TO FORM 2A

Insurance Card

MISSISSIPPI DIVISION OF

MEDICAID

123-456-7897

John Doe

BlueCross BlueShield of Mississippi

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association. www.bcbsms.com

[redacted]

ID # [redacted]

PLAN CODES 730 230

COMMUNITY PLUS PHARMACY NETWORK

MEDICAL HOME INFORMATION FORM

1. Child's Name _____

2. Does your child have a Medicaid Card? _____Yes _____No

3. Does you child have other Health Insurance? _____Yes _____No

4. Is your child in the WIC Program? _____Yes _____No

5. When you child has been sick, where did you take him/her for treatment?

_____
Name Address

6. Are you satisfied with your child's health care? _____Yes _____No

7. Do you need help finding health care for your child? _____Yes _____No

8. Has your child ever been to a dentist? _____Yes _____No

If yes, what dentist did your child see? _____Yes _____No

_____
Name Address

Were you satisfied? _____Yes _____No

9. Where does your child get his/her immunizations (shots) ?

_____
Name Address

10. Do you use the public health department? _____Yes _____No

If yes, for what service(s)?

_____

11. Is there anything about your child's health, development, or behavior that you are concerned about?

_____
_____

"Medical Home" is an ongoing source of continuous, accessible health care obtained for that "Home".

CHILD HEALTH RECORD — FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER:_____

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

PERSON INTERVIEWED:_____ DATE:_____ RELATIONSHIP:_____

NAME OF INTERVIEWER:_____ TITLE:_____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS CHILD'S BIRTH WEIGHT?			_____lbs., _____oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)*?			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUENT ____SORE THROAT; _____COUGH; _____URINARY INFECTIONS OR TROUBLE URINATING; _____STOMACH PAIN, VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)*?	*		
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?			*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)*?	*		
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?			
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*		*If "yes" ask:* WHEN DID IT LAST HAPPEN?_____ WHAT MEDICINE?_____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*			WHAT MEDICINE?_____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START?_____HOW OFTEN?_____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			(PHYSICIAN'S NAME:_____)
21. HAS CHILD HAD: __ BOILS, __ CHICKENPOX, __ ECZEMA, ___ GERMAN MEASLES, ___ MEASLES, _____MUMPS, ___ SCARLET FEVER, _____WHOOPING COUGH?			
22. HAS CHILD HAD: __ HIVES, __ POLIO?	*		
23. HAS CHILD HAD: __ ASTHMA, __ BLEEDING TENDENCIES __ DIABETES, __ EPILEPSY, __ HEART/BLOOD VESSEL DISEASE, __ LIVER DISEASE, __ RHEUMATIC FEVER, __ SICKLE CELL DISEASE?	*		*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)*? a WHEN EATING ANY FOODS?_____ b WHEN TAKING ANY MEDICATION?_____ c WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.?_____	*		*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

** If starred (*) questions have "yes" answers, go to question 25.*

INTERVIEWER: GO TO FORM 4

PERSON INTERVIEWED: _____ DATE: _____ RELATIONSHIP: _____

NAME OF INTERVIEWER: _____ TITLE: _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____NO, _____YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____NO, _____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH). _____

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET? _____

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE. _____

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____NO, _____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO _____EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO _____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____NO, _____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

_____

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

Mississippi Action For Progress, Inc.

PARENT AUTHORIZATION FOR MEDICAL SERVICES
Autorización de los Padres para Servicios Médicos

Child's Name/*Nombre del niño* _____ **Date/*Fecha*** _____

Center/*Centro* _____ **County/*Condado*** _____

Dear Parent/*Recordado Padre (Madre)*:

As a student at Mississippi Action for Progress, Inc., your child is eligible to take advantage of the Medical Program that we offer. / *Como estudiante de Mississippi Action for Progress, Inc., su hijo(a) es elegible para tomar ventaja del programa Médico que ofrecemos.*

This program includes/ *Este programa incluye:*

Childhood Immunization/*Inmunizaciones Infantiles*
Medical Examination/*Exanimación Médica*
Hematocrit Screening/*Prueba de Hematocritos*
Visual Screening/*Prueba Visual*
Speech Language/Hearing Screening/ *Pruebas de Dicción/Pruebas Auditivas*
Mental Health Screening/*Pruebas de Salud Mental*
Emergency Medical/Dental Treatment/*Tratamientos de Urgencia Médicos y Dentales*
Dental Screening/*Exanimación Dental*
Follow-up treatment on Medical Examination, when necessary/*Seguimiento de Tratamiento de Examen Médico, cuando sea necesario*

In order to prevent any delay in your child receiving the services stated above, we are requesting that you consent at this time./ *Para prevenir demoras con el recibimiento de los servicios para su hijo/a, mencionados anteriormente, solicitamos quede su permiso inmediatamente.*

Our office will keep you informed as each procedure takes place and inform you of the outcome of same. *Nuestra oficina le mantendrá informado a medida que se haga cada procedimiento y le informara sobre el resultado del mismo.*

I have read this letter and give permission for my child to receive the services. */Yo he leído esta información y doy mi permiso para que mi hijo/a reciba este servicio.*

_____ _____
Signature of Parent or Guardian/Firma de el Padre o Tutor *Date/Fecha*

If you do not wish for your child to participate in one of the above mentioned procedures, please specify. / *Si usted no desea que su hijo/a participe en cualquiera de los procedimientos mencionados anteriormente, por favor especifiquelo*

_____

_____

_____

_____ _____
Signature of Parent or Guardian/Firma de el Padre o Tutor *Date/Fecha*

FORM 221-B

WHITE COPY-Parent
YELLOW COPY-Child's Folder
PINK COPY-Area Nurse

MISSISSIPPI ACTION FOR PROGRESS, INC.
1751 Morson Road — Jackson, Mississippi 39209
Telephone(s): (601) 923-4100/923-4101

PARENT AUTHORIZATION FOR DENTAL SERVICES

Student's Name _____ Age _____ Unit _____

Center _____ County _____

SERVICES	YES	NO	LOCATION	PROVIDER
Screening			Classroom	Dental Coordinator, Family Services Coordinator and Teacher
Examination			Dental Office	Dentist
X-Rays				

By way of the signature below, I understand the dental services to be provided to my child and give approval for the completion of the services checked:

Screening—Examination:

Parent or Guardian *Date* *Witness* *Date*

SERVICES	YES	NO	LOCATION	PROVIDER
Follow-Up			Dental Office	Dentist
Extraction				
Fillings				
Chrome Crown				
Pulpotomy				
Special Services				
Other				

By way of the signature below, I understand the dental services to be provided to my child and give approval for the completion of the services checked:

Follow-Up:

Parent or Guardian *Date* *Witness* *Date*

MISSISSIPPI ACTION FOR PROGRESS, INC.

CONSENT FOR CHILD'S EMERGENCY MEDICAL/DENTAL TREATMENT
(By Parent or Guardian)

I,_____, hereby give my consent for emergency medical or dental treatment of the child or children listed below by any licensed physician or dentist while under the care of Mississippi Action for Progress, Inc., (MAP) child care provider, and for transport of the child or children to and from the source of emergency.

Parent/Guardian

This care may include examinations and any tests which, in the opinion of the physician or dentist, are deemed necessary or advisable.

This does not include the right to perform surgical operations without my further consent, except in the case of an emergency and where after an effort has been made to locate me, I am found unavailable.

This consent is valid for one year after the date signed. The purpose of this form has been explained to me.

NAMES	BIRTHDAYS
_____	_____
_____	_____
_____	_____
_____	_____

Signature:_____ Witness:_____

Relationship:_____

I have explained to_____ the purpose of this consent form.

Name of Parent/Guardian

Signature of Head Start Staff:_____ Date:_____

Mississippi Action For Progress, Inc.

DENIAL OF CONSENT FOR DENTAL/MEDICAL SERVICES

NEGACION DE PERMISO PARA EL SERVICIO DENTAL O MEDICO

☐ Medical / *Médico* ☐ Dental / *Dental*

As a parent or legal guardian of / *Como padre/madre o guardián legal de:*

_____
Name of child / *Nombre del niño*

It is my desire that no dental/medical screening and follow-up be provided to my child by Head Start. I understand that this screening/follow-up is recommended and that it will be provided at no cost. I accept the consequences of this action and in no way hold Head Start responsible for any future dental/medical problems resulting from this lack of dental/medical screening/follow-up.

* * * * * * * * * * *

Es mi deseo que el Head Start no provea el examen y seguimiento dental o médico para mi hijo/a. Comprendo que este examen/seguimiento ha sido recomendado por el doctor y no tendrá costo alguno. Acepto las consecuencias que puedan resultar de esta negación y de ninguna manera culpare al Head Start como responsable si en un futuro el niño/a resulta con problemas dentales/médicos como resultado de la falta de este examen/seguimiento.

_____ _____
Name / *Nombre* Signature / *Firma*

_____ _____
Parent's Phone # / *Telefono de los Padres* Date / *Fecha*

_____ _____
Witness Name / *Nombre del Testigo* Witness Signature / *Firma del Testigo*

_____
Date / *Fecha*

White – Child's Folder Yellow – Parent Pink – Regional Office

CHILD HEALTH RECORD

FORM 4. IMMUNIZATIONS

TO BE STARTED BY HEAD START STAFF AT PARENT INTERVIEW,
THEN USED BY PHYSICIAN OR CLINIC FOR COMPLETING RECORD FOR HEAD START.

CHILD'S NAME _____ **SEX** _____ **BIRTHDATE** _____

HEAD START CENTER _____ **PHONE** _____

ADDRESS _____

PARENT OR GUARDIAN **ADDRESS**

_____

1. IMMUNIZATIONS

VACCINE	DATE GIVEN DAY/MO/YR	DOCTOR OR CLINIC	DATE NEXT DOSE DUE
D T P			
Td			
DT			
POLIO -OPV			
MMR			
HIB - IF POSSIBLE SPECIFY VACCINE HBOC, PRP-OMP, OR PRP-D			
HB (AT BIRTH)			
HBIG (AT BIRTH)			
OTHER			

2. EXEMPTIONS If a child cannot or should not receive a particular immunization, write one of the following reasons in the "Doctor or Clinic" column.

(a) HAS HAD DISEASE (attach physician's note). For Rubella only a serologic test is a valid exemption.
(b) ALLERGIC TO _____ (specify allergen and attach physician's note).
(c) PARENT'S WILL NOT CONSENT (Attach parent consent form).

3. CERTIFICATION OF PREVIOUS IMMUNIZATIONS

I hereby attest that I have seen documentation of any immunizations the child received prior to enrollment in Head Start.

Signature _____ Title _____ Date _____

INTERVIEWER: GO TO FORM 5

Mississippi Action For Progress, Inc.

CHILD'S DENTAL HEALTH HISTORY

Yes___No___ 1. Does the family have a regular dentist?
Name/Address_____

Yes___No___2. Has the child ever been examined or treated by a dentist?
If yes, Name/Date_____

Yes___No___3. Does the child regularly brush his/her teeth?

Yes___No___4. Does the parent supervise the child's tooth brushing?

Yes___ No___5. Has the child ever complained about: Teeth___Gum___Mouth_____?

Yes___No___6. Has the child ever had a tooth pulled?

Yes___No___7. Has the child ever had an accident involving the mouth?
If yes, explain_____

Yes___No___8. Has the child ever lived or been living where water supply was fluoridated?

Yes___No___9. Has the child taken or is he/she presently taking a dietary supplement?
If yes, give date of initial prescription_____
Give brand name and dosage_____

Yes___No___10. Does the child have any of the following habits?
_____Thumb Sucking_____Lip Biting_____Lip Sucking_____Nail Biting
_____Take Bottle to Sleep_____Uses Bottle during Day/Night

MEDICAL HEALTH SUMMARY

Yes___No___1. Does the child take any medication?
List:_____

Yes___No___2. Does the child have any special medical problems?

Yes___No___3. Does the child have any allergies?

Yes___No___4. Does the child have negative reaction to medication?
Describe:_____

Name and address of attending physician:_____

Additional information:_____

_____ _____
Child's Name Parent/Guardian Name

_____ _____
Birth Date Address & Phone Number

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No____Unknown____Yes____
   - Fluoridated water? No____Unknown____Yes____
   - Fluoride Supplement diet? (tablets____, liquid____) No____Unknown____Yes____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART I. TO BE COMPLETED BY HEAD START STAFF

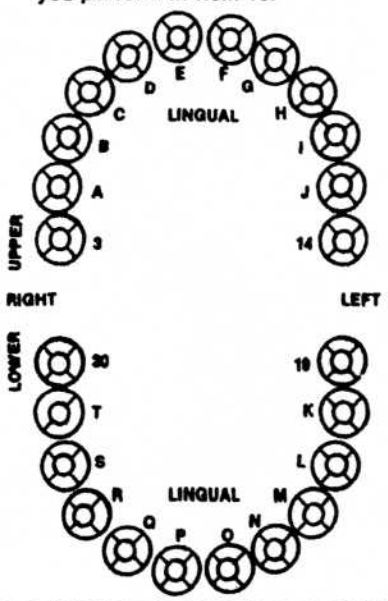
3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____Date last visit_____
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type_____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (○), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___Is, ___Is not) complete. If not, explain here, as well as items checked.
   _____
   _____
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

MISSISSIPPI ACTION FOR PROGRESS, INC.

1751 MORSON ROAD, JACKSON, MS 39209

DENTAL HEALTH RECORD

NAME_____ CENTER_____

ADDRESS_____ COUNTY_____

PARENT/GUARDIAN_____ ADDRESS_____

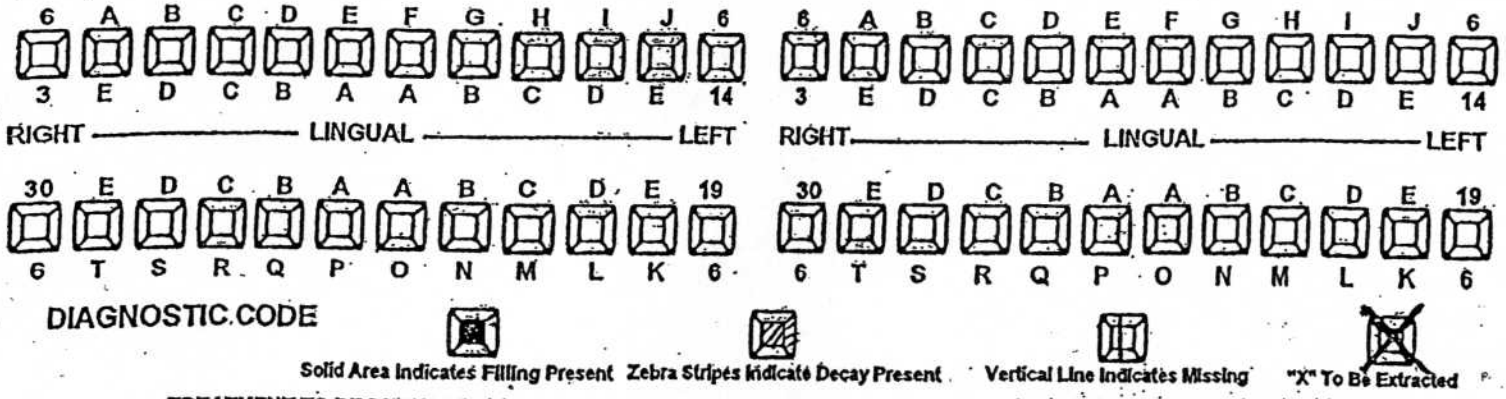
SEX_____AGE_____UNIT_____ SCREENING CATEGORY: I II III IV

MEDICAID OR INSURANCE NUMBER:_____ DENTIST NAME_____

PLEASE WRITE LEGIBLY WHEN COMPLETING THIS FORM

1ST COPY- HEALTH FOLDER; 2ND COPY-DENTIST STATEMENT; 3RD COPY-STATEMENT FOR EXAM

1. Chart findings on diagnostic chart below using symbols suggested in the diagnostic code.
2. Enter tentative treatment plan for each service to be provided along with the fee using suggested treatment codes when appropriate.
3. Mail to AREA NURSE for approval before beginning treatment.
4. Upon completion of treatment, enter date completed, service provided, and fee charged in treatment record using suggested treatment codes when appropriate.
5. Sign form to certify that listed services have been completed.
6. This dental form becomes a permanent record and cannot be used in lieu of a statement.
7. To expedite payment, forward your itemized statement along with dental records.



DIAGNOSTIC CODE

Solid Area Indicates Filling Present Zebra Stripes Indicate Decay Present Vertical Line Indicates Missing "X" To Be Extracted

TREATMENT TO BE PERFORMED

List each types of treatment to be performed on a separate line.
Refer to teeth as indicated on chart above.
Itemize charges to be made for each service.

	DESCRIPTION	FEE

Treatment authorized for items not crossed out above.

TREATMENT CODE

Material
- A - Amalgam
- S - Silicate
- P - Plastic
- C - Steel Crown
- O - Other

Surface
- M - Metal
- D - Distal
- O - Occulusal
- L - Lingual
- I - Incisal
- F - Facial

TREATMENT TO BE PERFORMED

List each types of treatment on a separate line.
Refer to teeth as indicated on chart above.
Itemize charges for each service.

Date	Tooth	Description	Fee
		TOTAL	

I certify that the above charted and listed services have been completed.

Signature of Dentist_____ Date_____

PROGRAM SERVICES DIRECTOR

Address_____

Federal ID#_____

MISSISSIPPI ACTION FOR PROGRESS, INC.
1751 Morson Road – Jackson MS 39209
Telephone / Teléfono: (601) 923-4100

RESULT OF SCREENING / *RESULTADOS DE PUEBAS DIAGNOSTICAS*

This is to inform you of your child's results of screening: / *Le informamos que su niño (a) resultados de puebas diagnosticas*

_____
Child's Name / *Nombre del Niño(a)*

Teacher(s): Please place a check in the appropriate ( ) indicating passed or failed for each screening.
Profesorado: Por favor marque en el paréntesis apropiado ( ) indicando que pasó o no paso cada examen

*Passed Screenings/*Pasó los Exámenes*		**Failed Screenings/*No pasó los Exámenes*
( )	Brigance	( )
( )	Speech/Language/*Dicción*	( )
( )	Hearing/*Auditivos*	( )
( )	Vision/*Vision*	( )
( )	Battelle	( )
( )	Dental/*Dental*	( )
( )	Blood Pressure/*Presión Arterial*	( )
( )	Hemoglobin/Hematocrit/*Hemoglobina/Hematocrito*	( )
( )	Physical Exam/*Examen Físico*	( )
( )	Lead/*Plomo*	( )
( )	Others/*Otro* _____	( )

No other services are required at this time. / *No se requieren otras pruebas en la actualidad.
****** Follow-up or further evaluation is needed. / *Seguimiento u otro examen es necesario.***

_____
Teacher/ *Maestra* Date/*Fecha*

_____
Parent/*Padre o Madre* Date/*Fecha*

Copy to parent
Copy in child's folder

Revised April 2010

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE?_____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES?

	Yes	No
3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS?		
(a) If "yes", what kind are they? _____		
(b) Do they contain iron?		
(c) Do they contain fluoride?		
(d) Were they prescribed?		
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS?	*	
5. IS YOUR CHILD ON A SPECIAL DIET?	*	
(a) What kind? _____		
6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH?	*	
7. DOES YOUR CHILD TAKE A BOTTLE?	*	
8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD?	*	
9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING?	*	
10. DOES YOUR CHILD OFTEN HAVE:		
(a) Diarrhea?	*	
(b) Constipation?	*	
11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?	*	

12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?

Approximate Number of Times a Week *(circle the number(s) nearest to parent's answer)*

(a) Milk, cheese, yogurt.	0*	1*	2*	3	4	5	6	7	7+
(b) Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter.	0*	1*	2*	3	4	5	6	7	7+
(c) Rice, grits, bread, cereal, tortillas.	0*	1*	2*	3	4	5	6	7	7+
(d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.	0*	1*	2	3	4	5	6	7	7+
(e) Oranges, grapefruit, tomatoes (fruit/juice).	0*	1*	2*	3	4	5	6	7	7+
(f) Other fruits and vegetables.	0*	1*	2	3	4	5	6	7	7+
(g) Oil, butter, margarine, lard.	0*	1*	2	3	4	5	6	7	7+*
(h) Cakes, cookies, sodas, fruit drinks, candy.	0	1	2	3	4	5	6	7	7+*

***Starred answers may require follow-up. Explain details or give additional comments here.*

PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST

13. GROWTH

DATE	AGE	HEIGHT *(no shoes, to nearest 1/8 in.)*	WEIGHT *(light clothing, to nearest 1/4 lb..)*
	_____yrs._____mo.		
	_____yrs._____mo.		
	_____yrs._____mo.		

14. ANEMIA SCREEN

	DATE	HEMOGLOBIN*	OR HEMATOCRIT *
SCREENING			
RESCREENING			

**Hgb less than 11 or Hct less than 34 require follow-up*

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION

(Review items 2 through 13. If there are answers in starred (*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)

- ☐ Suspect dietary problem or inadequate food intake *(from Questions 2 to 12)*
- ☐ Hgb. less than 11 gm. or Hct. less than 34% *(from Question 14)*
- ☐ Underweight *(weight less than typical, from Growth Chart 1 or 4)*
- ☐ Overweight *(weight greater than typical, from Growth Chart 1 or 4)*
- ☐ Short for Age *(height less than typical, from Growth Chart 2 or 5)*
- ☐ Wt. for Ht. *(greater or less than typical, from Growth Chart 3 or 6)*

COMMENTS *(use additional page if needed)*

Signature_____ Title_____ Date_____

GROWTH CHARTS
WITH REFERENCE PERCENTILES
FOR BOYS
2 TO 18 YEARS OF AGE

Stature for Age
Weight for Age
Weight for Stature

NAME _____ **RECORD #** _____

DATE OF BIRTH _____

Date of Measurement	Age Years	Age Months	Stature	Weight		

These charts to record the growth of the individual child were constructed by the National Center for Health Statistics in collaboration with the Center for Disease Control. The charts are based on data from national probability samples representative of boys in the general U.S. population. Their use will direct attention to unusual body size which may be due to disease or poor nutrition.

Measuring: Take all measurements with the child in minimal indoor clothing and without shoes. Measure stature with the child standing. Use a beam balance to measure weight.

Recording: First take all measurements and record them on this front page. Then graph each measurement on the appropriate chart. Find the child's age on the horizontal scale; then follow a vertical line from that point to the horizontal level of the child's measurement (stature or weight). Where the two lines intersect, make a cross mark with a pencil. In graphing weight for stature, place the cross mark directly above the child's stature at the horizontal level of his weight. When the child is measured again, join the new set of cross marks to the previous set by straight lines.

Do not use the weight for stature chart for boys who have begun to develop secondary sex characteristics.

Interpreting: Many factors influence growth. Therefore, growth data cannot be used alone to diagnose disease, but they do allow you to identify some unusual children.

Each chart contains a series of curved lines numbered to show selected percentiles. These refer to the rank of a measure in a group of 100. Thus, when a cross mark is on the 95th percentile line of weight for age it means that only five children among 100 of the corresponding age and sex have weights greater than that recorded.

Inspect the set of cross marks you have just made. If any are particularly high or low (for example, above the 95th percentile or below the 5th percentile), you may want to refer the child to a physician. *Compare* the most recent set of cross marks with earlier sets for the same child. If he has changed rapidly in percentile levels, you may want to refer him to a physician. Rapid changes are less likely to be significant when they occur within the range from the 25th to the 75th percentile.

In normal teenagers, the age at onset of puberty varies. Rises occur in percentile levels if puberty is early, and these levels fall if puberty is late.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION, NATIONAL CENTER FOR HEALTH STATISTICS, AND CENTER FOR DISEASE CONTROL

Mississippi Action for Progress, Inc.
Teacher's Mental Health Observation Checklist

Center: _____ Child's Name: _____ Child's Age _____

Teacher's Name: _____ Date completed: _____

Please mark each box appropriately, placing a check for yes or no in the appropriate box that best describes the child's behavior.

Attention	Yes	No	Yes	No	Sensory	Yes	No	Yes	No
1. Unable to sit still for activities	☐	☐	☐	☐	1. Dislike being touched	☐	☐	☐	☐
2. Difficult to calm when upset	☐	☐	☐	☐	2. Withdrawn from others	☐	☐	☐	☐
3. Does not appear happy and content	☐	☐	☐	☐	3. Hit, kick or bit others & aggressive in play	☐	☐	☐	☐
4. Little to no laughter	☐	☐	☐	☐	4. Has difficulty w/fine motor tasks	☐	☐	☐	☐
5. Difficult transitioning from one activity to another	☐	☐	☐	☐	5. Easily fatigued during physical activities	☐	☐	☐	☐
6. Being destructively with toys and other things	☐	☐	☐	☐					

Social-Emotional					Communication				
1. Easily frustrated	☐	☐	☐	☐	1. Will not follow simple instructions	☐	☐	☐	☐
2. Difficulty playing w/ peers	☐	☐	☐	☐	2. No or little verbalizing	☐	☐	☐	☐
3. Aggressive or destructive in play	☐	☐	☐	☐	3. Limited consonant sounds(e.g. p,b,m,n,d,t,w)	☐	☐	☐	☐
4. Tantrums easily	☐	☐	☐	☐	4. Limited usage of words or phrases	☐	☐	☐	☐
5. Cries for no apparent reason	☐	☐	☐	☐					
6. Does not follow instructions given by teacher (adults)	☐	☐	☐	☐					

RATING SCALE: **31% > No = Passed (8 or more)** _____ **70% > Yes = Failed (14 or more)** _____

Teacher's Signature: _____ **Date:** _____

Comments: _____

Screening should be done within 45 calendar days of child's enrollment. If child fails the initial screening, re-screen in two (2) weeks. If re-screening results indicate "failed" at this time, referral should be made to the mental health consultant. Please use red ink to indicate re-screening.

Source: Center for Family and community Partnership University of New Mexico

MAP, INC. 2009

White – Child's Folder Yellow – Child's Education Folder Pink – Mental Health Provider (If necessary)