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 health 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 health 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 Health 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

REVISED MAY 2010
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'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):

   Street Address: _____________________________

   City: _____________________________ 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.): _____________________________

   (Enter child's physician and clinic):

   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).

   _____________________________

   Father: _____________________________

   Mother: _____________________________

   Brothers & Sisters (oldest first):

   (1) _____________________________

   (2) _____________________________

   (3) _____________________________

   Other (Specify relationship):

   (1) _____________________________

   (2) _____________________________

   (3) _____________________________

   (Use additional page if needed)

INTERVIEWER: GO TO FORM 2A
Insurance Card

MISSISSIPPI DIVISION OF MEDICAID

123-456-7897

John Doe

BlueCross BlueShield of Mississippi

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 your child have other Health Insurance? _____ Yes _____ No

4. Is your child in the WIC Program? _____ Yes _____ No

5. When your 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".
<table>
<thead>
<tr>
<th><strong>CHILD HEALTH RECORD</strong></th>
<th><strong>FORM 2A, HEALTH HISTORY</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILD'S NAME:</strong></td>
<td><strong>SEX:</strong></td>
</tr>
<tr>
<td><strong>BIRTHDATE:</strong></td>
<td><strong>DATE:</strong></td>
</tr>
<tr>
<td><strong>PERSON INTERVIEWED:</strong></td>
<td><strong>RELATIONSHIP:</strong></td>
</tr>
<tr>
<td><strong>NAME OF INTERVIEWER:</strong></td>
<td><strong>TITLE:</strong></td>
</tr>
<tr>
<td><strong>PREGNANCY/BIRTH HISTORY</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?</td>
<td></td>
</tr>
<tr>
<td>2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?</td>
<td></td>
</tr>
<tr>
<td>3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?</td>
<td></td>
</tr>
<tr>
<td>4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?</td>
<td></td>
</tr>
<tr>
<td>5. WHAT WAS CHILD'S BIRTH WEIGHT?</td>
<td>lbs., oz.</td>
</tr>
<tr>
<td>6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?</td>
<td></td>
</tr>
<tr>
<td>7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?</td>
<td></td>
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<tr>
<td>8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?</td>
<td></td>
</tr>
<tr>
<td>9. IS MOTHER PREGNANT NOW?</td>
<td>(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)</td>
</tr>
<tr>
<td><strong>HOSPITALIZATIONS AND ILLNESSES</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?</td>
<td></td>
</tr>
<tr>
<td>11. HAS CHILD EVER HAD A SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?</td>
<td></td>
</tr>
<tr>
<td>12. HAS CHILD EVER HAD A SERIOUS ILLNESS?</td>
<td></td>
</tr>
<tr>
<td><strong>HEALTH PROBLEMS</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td>13. DOES CHILD HAVE FREQUENT ___SORE THROAT; ___COUGH; ___URINARY INFECTIONS OR TROUBLE URINATING; ___STOMACH PAIN, VOMITING, DIARRHEA?</td>
<td></td>
</tr>
<tr>
<td>14. DOES CHILD HAVE DIFFICULTY SEEING (Squint, cross eyes, look closely at books)?</td>
<td></td>
</tr>
<tr>
<td>15. IS CHILD WEARING (or supposed to wear) GLASSES?</td>
<td>(If “yes”) WAS LAST CHECKUP MORE THAN ONE YEAR AGO?</td>
</tr>
<tr>
<td>16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?</td>
<td></td>
</tr>
<tr>
<td>17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND (Rear end, anus, butt) WHILE ASLEEP?</td>
<td></td>
</tr>
<tr>
<td>18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE?</td>
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<tr>
<td>19. IS CHILD TAKING MEDICINE FOR SEIZURES?</td>
<td></td>
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<tr>
<td>20. IS CHILD TAKING ANY OTHER MEDICINE NOW? (Special consent form must be signed for Head Start to administer any medication).</td>
<td></td>
</tr>
<tr>
<td>21. HAS CHILD HAD: ___BOILS, ___CHICKENPOX, ___ECZEMA, ___GERMAN MEASLES, ___MEASLES, ___MUMPS, ___SCARLET FEVER, ___WHOOPING COUGH?</td>
<td></td>
</tr>
<tr>
<td>22. HAS CHILD HAD: ___HIVES, ___POLIO?</td>
<td></td>
</tr>
<tr>
<td>23. HAS CHILD HAD: ___ASTHMA, ___BLEEDING TENDENCIES, ___DIABETES, ___EPILEPSY, ___HEART/BLOOD VESSEL DISEASE, ___LIVER DISEASE, ___RHEUMATIC FEVER, ___SICKLE CELL DISEASE?</td>
<td></td>
</tr>
<tr>
<td>24. DOES CHILD HAVE ANY ALLERGY PROBLEMS (Rash, itching, swelling, difficulty breathing, sneezing)?</td>
<td></td>
</tr>
<tr>
<td>a. WHEN EATING ANY FOODS?</td>
<td></td>
</tr>
<tr>
<td>b. WHEN TAKING ANY MEDICATION?</td>
<td></td>
</tr>
<tr>
<td>c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.?</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
</tr>
<tr>
<td>DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?</td>
<td></td>
</tr>
<tr>
<td>ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES?</td>
<td></td>
</tr>
<tr>
<td>DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?</td>
<td></td>
</tr>
</tbody>
</table>

*If starred (*) questions have “yes” answers, go to question 25.*
CHILD HEALTH RECORD

FORM 2 - HEALTH HISTORY (Continued)

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).

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Earlier</th>
<th>When Expected</th>
<th>Later</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Sit up without help</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Crawl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Walk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Talk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Feed and dress self</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) Learn to use the toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(g) Respond to directions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(h) Play with toys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Use crayons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(j) Understand what is said to him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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/Examinación Médica
- Hematocrit Screening/Prueba de Hematocritos
- Visual Screening/Prueba Visual
- Speech Language/Hearing Screening/ Pruebas de Diccion/Pruebas Auditivas
- Mental Health Screening/Pruebas de Salud Mental
- Emergency Medical/Dental Treatment/Tratamientos de Urgencia Médicos y Dentales
- Dental Screening/Examinación 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.

_________________________________________________________ Date/Fecha __________
Signature of Parent or Guardian/Firma de el Padre o Tutor

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 especifíquelo

_________________________________________________________

Signature of Parent or Guardian/Firma de el Padre o Tutor

FORM 221-B

WHITE COPY-Parent
YELLOW COPY-Child’s Folder
PINK COPY-Area Nurse
**PARENT AUTHORIZATION FOR DENTAL SERVICES**

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>LOCATION</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td></td>
<td></td>
<td>Classroom</td>
<td>Dental Coordinator, Family Services Coordinator and Teacher</td>
</tr>
<tr>
<td>Examination</td>
<td></td>
<td></td>
<td>Dental Office</td>
<td>Dentist</td>
</tr>
<tr>
<td>X-Rays</td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>LOCATION</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-Up</td>
<td></td>
<td></td>
<td>Dental Office</td>
<td>Dentist</td>
</tr>
<tr>
<td>Extraction</td>
<td></td>
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<tr>
<td>Fillings</td>
<td></td>
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<tr>
<td>Chrome Crown</td>
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<tr>
<td>Pulpotomy</td>
<td></td>
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<tr>
<td>Special Services</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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, ________________, Parent/Guardian, 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.

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: ___________________________
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 # / Teléfono 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
## 1. IMMUNIZATIONS

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE GIVEN DAY/MO/YR</th>
<th>DOCTOR OR CLINIC</th>
<th>DATE NEXT DOSE DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D T P</td>
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<td>MMR</td>
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<td>Hib - IF POSSIBLE</td>
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<tr>
<td>SPECIFY VACCINE</td>
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<tr>
<td>HB0C, PRP-OMP, OR PRP-D</td>
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<tr>
<td>HB (AT BIRTH)</td>
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<tr>
<td>HBIG (AT BIRTH)</td>
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<tr>
<td>OTHER</td>
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## 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 ____________
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

CHILD'S NAME: ____________________________ SEX: ___________ BIRTHDATE: ____________________________

HEAD START CENTER: ______________________ PHONE: ____________________________

ADDRESS: ________________________________

1. IS THE CHILD NOW RECEIVING:
   - Topical Fluoride Application? No, Unknown, Yes
   - Fluoridated water? No, Unknown, Yes
   - Fluoride Supplement diet? No, Unknown, Yes

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?
   - Fluoridated water? No, Yes
   - Fluoride Supplement diet? No, Yes

3. CHILD ( HAS, HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name: ______________________ Date last visit: ___________

4. CHILD ( IS, NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name: ______________________

5. CHILD ( IS, NOT) RECEIVING MEDICATION.
   Type: ______________________

6. CHILD IS REPORTED TO HAVE (Give details or attach Health History, Form 2A).

   - Allergies
   - Liver Dis.
   - Rheumatic Fever
   - Sickle Cell Dis.
   - Other (List Below)

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

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 YA. A.O.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)
   - 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,
   - c. Dietary problem(s)
   - d. Developmental problem(s)
   - e. Harmful oral habits
   - f. Needs fluoride supplement
   - g. Oral hygiene

   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
# 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**

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 CODE

- **Material**
  - A - Amalgam
  - S - Silicate
  - P - Plastic
  - C - Steel Crown
  - O - Other
- **Surface**
  - M - Metal
  - D - Distal
  - O - Occlusal
  - L - Lingual
  - I - Incisal
  - F - Facial

### TREATMENT TO BE PERFORMED

List each type 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.

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>FEE</th>
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<tbody>
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</table>

**TREATMENT TO BE PERFORMED**

List each type 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.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOOTH</th>
<th>DESCRIPTION</th>
<th>FEE</th>
</tr>
</thead>
<tbody>
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</table>

**TOTAL**

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

Signature of Dentist

**Date**

**Program Services Director**

**Address, Federal ID#**
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 puebadas 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

( ) 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

**Failed Screenings/No pasó los Exámenes

( )

*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
### Child Health Record

**Child's Name:**

**Sex:**

**Birthdate:**

#### Dietary Habits

**1.** What foods does your child especially like?

**2.** Are there any foods your child dislikes?

**3.** Does your child take vitamins and mineral supplements?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

  (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?

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

**5.** Is your child on a special diet?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

  (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:

<p>| | | |</p>
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  (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?

<p>| | | | | | | |</p>
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  (a) Milk, cheese, yogurt.

  (b) Meat, poultry, fish, eggs; or dried beans/peas, peanut butter.

  (c) Rice, grits, bread, cereal, tortillas.

  (d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.

  (e) Oranges, grapefruit, tomatoes, fruit/fruit juice.

  (f) Other fruits and vegetables.

  (g) Oil, butter, margarine, lard.

  (h) Cakes, cookies, sodas, fruit drinks, candy.

**13.** Growth

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Height (no shoes, to nearest 1/8 in.)</th>
<th>Weight (light clothing, to nearest 1/4 lb.)</th>
<th>Approximate Number of Times a Week (circle the number(s) nearest to parent's answer)</th>
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</table>

**14.** Anemia Screen

<table>
<thead>
<tr>
<th>Date</th>
<th>Hemoglobin*</th>
<th>Or Hematocrit*</th>
</tr>
</thead>
</table>

*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)

**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

<table>
<thead>
<tr>
<th>NAME</th>
<th>RECORD</th>
<th>DATE OF BIRTH</th>
</tr>
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<table>
<thead>
<tr>
<th>Date of Measurement</th>
<th>Age</th>
<th>Stature</th>
<th>Weight</th>
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<tr>
<td></td>
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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**

1. Unable to sit still for activities  
   - Yes No  
2. Difficult to calm when upset  
   - Yes No  
3. Does not appear happy and content  
   - Yes No  
4. Little to no laughter  
   - Yes No  
5. Difficult transitioning from one activity to another  
   - Yes No  
6. Being destructively with toys and other things  
   - Yes No  

**Sensory**

1. Dislike being touched  
   - Yes No  
2. Withdrawn from others  
   - Yes No  
3. Hit, kick or bit others & aggressive in play  
   - Yes No  
4. Has difficulty with fine motor tasks  
   - Yes No  
5. Easily fatigued during physical activities  
   - Yes No  

**Social-Emotional**

1. Easily frustrated  
   - Yes No  
2. Difficulty playing with peers  
   - Yes No  
3. Aggressive or destructive in play  
   - Yes No  
4. Tantrums easily  
   - Yes No  
5. Cries for no apparent reason  
   - Yes No  
6. Does not follow instructions given by teacher (adults)  
   - Yes No  

**Communication**

1. Will not follow simple instructions  
   - Yes No  
2. No or little verbalizing  
   - Yes No  
3. Limited consonant sounds (e.g. p,b,m,n,d,t,w)  
   - Yes No  
4. Limited usage of words or phrases  
   - Yes No  

**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

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