

COASTAL COMMUNITY ACTION, INC

HEAD START/EARLY HEAD START HEALTH ASSESSMENT REPORT 2009/10

Personal Data *Please bring your child's shot records with you to this visit *

Please Print Clearly - See other side for more required information

PARENT COMPLETE

Child's Name _____
(Last) (First) (Middle)

Birth Date: ____/____/____ (mm/dd/yyyy)

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Circle Yes or No

- Yes No** Are you concerned about your child's health, weight, development or behavior?
Yes No Has your child been seen by a provider for any health, weight, development or behavior concerns?
Yes No Does anyone in your family have a condition that has affected their health, weight, development or behavior? (Please explain in comment section)
Yes No Has your child had a dental exam by a dentist in the last 12 months?
Yes No Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

Parental Consent : I agree to allow my child's health care provider and CCA Head Start personnel to discuss information on this form.

Signature: _____ Date: _____

Recommendations to School Personnel Based on Health Assessment

HEALTH CARE PROVIDER COMPLETE

- Requesting School Follow Up No Recommendations, Concerns or Needs
 Child takes medicine for specific health conditions:

List Medications	Corresponding Condition
1	1
2	2
3	3

- Medication must be administered and/or available at school (Medication Administration Form required)
 Allergy *check below*

Type	Allergen (name)	Reaction (Check one)	Response required (Check one)
Food		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Local	<input type="checkbox"/> Epi-pen <input type="checkbox"/> Other <input type="checkbox"/> None
Insect		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Local	<input type="checkbox"/> Epi-pen <input type="checkbox"/> Other <input type="checkbox"/> None
Medicine		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Local	<input type="checkbox"/> Epi-pen <input type="checkbox"/> Other <input type="checkbox"/> None
Other		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Local	<input type="checkbox"/> Epi-pen <input type="checkbox"/> Other <input type="checkbox"/> None

- Developmental Concerns Identified (See comments below)
 Special Diet
 Guidance: _____
 Health-Related Recommendations to Enhance School Performance
 Please specify: _____
 School Health Forms ****Please attach when applicable**

Check box	Form Needed	Condition/ Diagnosis
<input type="checkbox"/>	Asthma Action Plan	
<input type="checkbox"/>	Health Care Plan(s)	
<input type="checkbox"/>	Individualized Nutrition Plan	
<input type="checkbox"/>	Medication Administration Form	
<input type="checkbox"/>	Diabetes Care Plan	

If this assessment was not completed in the child's regular health care provider's office, please provide a copy to the parent to give to the child's primary health care provider.

Health Care Professional's Certification

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: _____ Date: _____
 Provider's Signature: _____
 Practice/Clinic Name: _____
 Practice/Clinic Address: _____
 Practice/Clinic City, State & Zip: _____
 Practice Phone: _____ Fax: _____

Provider Stamp Here

PARENT COMPLETE

Child's Birth date: ___/___/___ (mm/dd/yyyy)
 Sex: Male Female
 County of Residence: _____
 Zip Code: _____
 Center/School your child will be attending: _____
 Place where your child gets regular health care:
 Health Department Private Doctor/HMO
 Hospital Clinic Other
 Community Health Center No regular place
 Doctor/Practice Name: _____

Race: Asian Black or African American
 White American Indian/Alaskan Native
 Bi-racial/multi-racial Native Hawaiian/ Pacific Islander
 Other: _____ Unspecified
Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Child has:
 Medicaid Private Insurance/HMO
 No insurance Other

Date of Health Assessment: ___/___/___
The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Immunizations - Attach a copy of immunization record

Pertinent Illnesses, Risks or Developmental Problems: (Check all that apply)

<input type="checkbox"/> Allergy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emotional/Behavioral	<input type="checkbox"/> Prematurity (<32 wks. EGA)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Encopresis	<input type="checkbox"/> Seizures/Convulsions
<input type="checkbox"/> Attention/Learning	<input type="checkbox"/> Enuresis (Daytime)	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Genetic Disorders	<input type="checkbox"/> Speech/Language
<input type="checkbox"/> Cancer/Leukemia	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> at risk for TB
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dental Problems		
<input type="checkbox"/> NONE		

Lead: date of test: ___/___/___ Results: ___/___/___

Head Start requires a blood lead test at 12 and 24 months of age, please note all past test dates and applicable results

Screening Results

Development	Screening Tool(s) Used: <input type="checkbox"/> 1 - PEDS <input type="checkbox"/> 2 - ASQ <input type="checkbox"/> 3 - IDI/CDI <input type="checkbox"/> 4 - PSC <input type="checkbox"/> 5 - ASQ-SE <input type="checkbox"/> 6 - Brigance	Developmental Domains	Within Normal	Concern Identified	Referred to Specialist	Comments
			1	2	3	
		Emotional/Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Language/Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Fine Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		Gross Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hearing

Screening Tool Used:
 OAE Audiometry Subjective (ages 0-3 only)

	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means failure at any frequency in either ear at >20dB

Pass
 Re-screen scheduled due to middle ear fluid. Re-screen in ___wks.
 Referral to Audiologist/ENT
 Previously diagnosed with hearing loss, no screening needed.

Vision

Please remember that vision screening is not a substitute for a complete eye exam.

Far:	Both	Right	Left
Test Used:			

Test performed with corrective lenses

Pass
 Referral to Eye Doctor (check if Y)
Refer if worse than 20/40 in either eye, a two line difference between eyes or unable to test.
 Child has a diagnosed vision condition AND has had an eye exam in last 12 months.

Physical Examination

Weight: ___lbs. Height: ___ft. ___in.
 Body Mass Index (BMI) - for age
 1 - Normal
 2 - Abnormal
 3 - At-Risk (85%ile to <95%ile)
 4 - Overweight (95%ile)

Blood Pressure: ___/___

Hematocrit: ___% OR Hemoglobin: ___gm/dl
 1 - Within normal range
 2 - >90th percentile (___%ile)

	Normal	Abnormal	
Vision/Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dental Referral made If yes:
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	
Dental (0-2 yrs. = scrng)	<input type="checkbox"/>	<input type="checkbox"/>	<i>Dentist</i> <input type="checkbox"/> Carolina Dental Home
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Back/Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Genital	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH CARE PROVIDER COMPLETE