Capital Area Head Start

It takes a community to raise a child
Keystone Human Services

Dear Physician,

Capital Area Head Start Follows the EPSDT guidelines. Children who are not up to date for all medical requirements may have their entry into our program delayed.
Infants must have a physical at ages: 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months.
Older children must have a yearly physical at ages: 3, 4, 5, 6, 8, and 10.

A signed physical exam includes:

_____ A. Hearing test with audiometer
_____B. Vision test (acuity and strabismus) If the child is untestable for hearing or vision please chart-child untestable at this time
_____ C. Hemoglobin or Hematocrit
_____ D. Lead screening
_____ E. Sickle Cell screening
_____ F. Blood Pressure
_____ G. Height & Weight (shoes off)
_____ H. Varivax or documentation that the child has had Varicella
_____ I. Head Circumference, if applicable

Children from the age of one to five have a higher risk of exposure to Lead. Please discuss with your patient the necessity of having Head Start children tested for Lead.

To avoid errors, please check to make sure that you have completed the following:

- **Sign the medical exam form, include your current telephone number**
- Use exact values in results column (e.g. vision (R) 20/20 (L) 20/30
- Blood Lead 5 mg/dl, not just (normal)
- Note any allergies and/or health problems- (Asthma must be noted. An asthma care plan must be filled out) See attached
- If any of the above screenings were done previously, please give dates.

3 Years olds: 3 OPV 4 DPT 1 MMR 1 Varivax 4 PCV (Required)
2 HEP A 3 HEP B 3 HIB + 1 booster in infancy or 1 HIB at 15 months or older.

4 Years olds: 4 OPV 5 DPT 2 MMR 1 Varivax 4 PCV (Required)
2 HEP A 3 HEP B 3 HIB + 1 booster in infancy or 1 HIB at 15 mos. or older.

Thank you for your help in serving children and families. If you have any questions, please do not hesitate to call 717-541-1795.

Sincerely,
Health Staff

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ASTHMA CARE PLAN

This form must be completed by a physician and returned to CAHS
Prior to a child participating in the classroom

Child:_____Date of Birth: _____

Parent's Name: _____ Address:_____

Head Start Center Child Attends:_____

_____ Child has a history of Asthma or RAD, but is currently not being treated routinely. **Child <u>will need</u> emergency medication at school.**

_____ Child diagnosed with Asthma or RAD and **<u>needs</u>** emergency **medication at school**.

_____ Child is not being treated for Asthma or RAD at this time and **<u>does not</u>** need medication at school.

This child's Asthma or RAD may be triggered by: _____

Activities for which this child has needed special attention in the past: _____

Activity restrictions: _____

Any other information you feel would be beneficial: _____

Medication

1. Medication: _____ Medication: _____

Dose: _____ Dose: _____

Time: _____ Time: _____

Routine or Emergency: _____ Routine or Emergency: _____

Physician's Name:_____ Signature _____
(Please Print)

Address: _____ Phone Number: _____

Date: _____/_____ /_____
Thank-you, C.A.H.S. Health Staff

KEYSTONE
CHILDREN & FAMILY SERVICES
"Advancing the Human Spirit"

3705 Elmwood Drive, Harrisburg, PA17110
Tel: 717.541.1795 Fax: 717.541.8226
www.keystonehumanservices.org

CHILD HEALTH ASSESSMENT FORM

CHILD'S NAME		**DOB:**		**DATE OF EXAM:**
PARENT'S NAME		**CENTER:**		**CLASS**:
ADDRESS		**CITY**	**STATE**	**PHONE NUMBER:**

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

Capital Area Head Start (CAHS) follows age specific EPSDT guidelines. This requires periodic physical assessments and routine immunizations for all children and pregnant mothers participating in the CAHS programs.

ALLERGIES to food or medicine (describe if any):

HEIGHT	**WEIGHT**	**BLOOD PRESSURE**
_____IN	_____LB	_____/_____

PHYSICAL EXAMINATION	**√ IF NORMAL**	**IF ABNORMAL-COMMENT**
HEAD/EARS/EYES/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

PLEASE ATTACH A COPY OF ALL IMMUNIZATIONS CURRENTLY AVAILABLE

HEALTH MAINTENANCE (enter date, or √ if done today, or WS for "will schedule")

SCREENING	**DATE TEST DONE**	**RESULTS**	**LIST IF RESULTS ARE PENDING, ABNORMAL OR NOT AT RISK**
LEAD			
ANEMIA			
Hearing (subjective until age 4)			
VISION (subjective until age 3)			
PROFESSIONAL DENTAL EXAM			

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

(PRINT) NAME of MEDICAL CARE PROVIDER:	**(SIGNATURE) of PHYSICIAN or CRNP:**
ADDRESS:	**LICENSE NUMBER:**
	DATE SIGNED:
CONTACT #:	**NEXT APPOINTMENT- MONTH/YR:**

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Allergy Care Plan

This form MUST be completed by a physician and returned to CAHS prior to child's start in classroom/center

Child: _____ Date of Birth: _____

Parent's Name: _____

Center Child Attends: _____ Classroom: _____

- Please list what the child is allergic to: _____
  - What are the **symptoms** and **severity** of the reaction when this child comes into contact with the allergen(s)? _____
    _____

- **IF THIS IS A FOOD ALLERGY**, please list all food(s) that must be excluded and/or substituted for this child while in class. CAHS cannot deprive children of meal components due to allergies or intolerances. *Please be specific*, as some children can be served certain foods, but not others (ex: child cannot drink liquid milk, but tolerates cheese and yogurt without issue):
  - **Food(s) that must be excluded from child's diet:** _____
    _____
  - **Food(s) that must be substituted:** (i.e. lactose intolerance – what dairy alternative must be served? Rice milk, Soy milk, etc.) _____
    _____

- Does this child take any medication for their allergy? Circle one: YES NO
  - Medication: _____
  - Dosage: _____
  - Frequency: _____

- What course of action should Head Start teachers/staff take if this child has an allergic reaction while in our care? Please **describe them in detail**:
  _____
  _____
  _____

- Any additional information you feel may be beneficial for CAHS to know about this child's allergy:
  _____
  _____

Physician's Name: _____ Signature: _____

Address: _____ Phone Number: _____

Date: _____/_____/ _____

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Child's Name: _____ DOB: _____

Thank you for partnering with Capital Area Head Start to ensure children receive necessary health services for a well-rounded educational experience.

Capital Area Head Start's Lead Screening Protocol follows our states EPSDT schedule of required screenings.

Your patient, a student of CAHS, does not have a lead screening on file. This information is needed to evaluate if follow up services are needed.

Lead Screening Date (s) _____, _____

Lead Screening Result (s) _____, _____

Lead Screening Assessment Date (Not at Risk**)**: _____

Medical Provider Signature_____ **Date** _____

Provider Phone Number: _____

If you have any questions, please contact a member of the CAHS Health Team at the information provided below.

Sincerely,

Capital Area Head Start
Health Coordinator
(717) 541-1795