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
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 will need emergency medication at school.

_____ Child diagnosed with Asthma or RAD and needs emergency medication at school.

_____ Child is not being treated for Asthma or RAD at this time and does not 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

3705 Elmwood Drive, Harrisburg, PA 17110
Tel: 717.541.1795 Fax: 717.541.8226
www.keystonehumanservices.org
# CHILD HEALTH ASSESSMENT FORM

<table>
<thead>
<tr>
<th>CHILD'S NAME</th>
<th>DOB:</th>
<th>DATE OF EXAM:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENT'S NAME</td>
<td>CENTER:</td>
<td>CLASS</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>CITY</td>
<td>STATE</td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>BLOOD PRESSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>______ IN</td>
<td>______ LB</td>
<td><strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

**PHYSICAL EXAMINATION**

- HEAD/EARS/EYES/THROAT
- TEETH
- CARDIORESPIRATORY
- ABDOMEN/GI
- GENITALIA/BREASTS
- EXTREMITIES/JOINTS/BACK/CHEST
- SKIN/LYMPH NODES
- NEUROLOGIC & DEVELOPMENTAL

*PLEASE ATTACH A COPY OF ALL IMMUNIZATIONS CURRENTLY AVAILABLE*

<table>
<thead>
<tr>
<th>HEALTH MAINTENANCE</th>
<th>DATE TEST DONE</th>
<th>RESULTS</th>
<th>LIST IF RESULTS ARE PENDING, ABNORMAL OR NOT AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCREENING</td>
<td></td>
<td></td>
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<tr>
<td>LEAD</td>
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<td></td>
</tr>
<tr>
<td>ANEMIA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing (subjective until age 4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VISION (subjective until age 3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROFESSIONAL DENTAL EXAM</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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:

CONTACT #:  NEXT APPOINTMENT- MONTH/YR:
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:
  o 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):
  o Food(s) that must be excluded from child’s diet: ___________________________
  o 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
  o Medication: ___________________________
  o Dosage: ___________________________
  o 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: _____/_____/_____

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