Dental Exam

Child's Name: _____ **DOB:** _____

DENTAL SERVICE RECEIVED:

☐ **PREVENTATIVE SERVICES**
☐ X-rays ☐ Cleaning ☐ Fluoride ☐ Oral Health Education ☐ Sealants

DENTAL DIAGNOSIS:

☐ Normal Examination/No Treatment Needed

☐ Dental Treatment Needed

☐ Cavities Number of Cavities_____ ☐ Early Childhood Caries (ECC)

☐ Other Diagnosis_____

DENTAL TREATMENT:

Dental Treatment Initiated ☐ Yes ☐ No

Describe Dental Treatment_____

Has all Dental Treatment been Completed? ☐ Yes ☐ No

Date of Next Visit for Treatment_____

NEXT DENTAL EXAMINATION:

Date Next Routine Dental Examination Due_____

DENTAL EXAM DATE: _____ **DATE FORM COMPLETED:** _____	**DENTIST STAMP (REQUIRED)**

Dental Provider Name: _____

Address: _____

Phone Number: _____

Dental provider Signature: _____

AGENCY USE ONLY

☐ **No Concerns** ☐ **(*) Refer to Health Assistant** **Date:** _____ **Initial:** _____
☐ **NOTATION OF REFERRAL MADE IN CASE NOTES (FSA)** **Date:** _____ **Initial:** _____
☐ **NOTATION OF FOLLOW-UP MADE IN CASE NOTES (HA)** **Date:** _____ **Initial:** _____

Crystal Stairs, Inc. Head Start
Child Pre-Admission Health Evaluation

Part A - Parental Consent/Consentimiento del Padre

_____ , born on _____ is being evaluated for
(Name of Child) (Birth Date)

Readiness to enter pre-school, CSI Head Start operates pre-school 3.5-8 hours a day 5 days a week. Please provide a health report for my child using the form below. I hereby authorize release of medical information contained in this report to CSI Head Start.

mi hijo/a esta siendo evaluado para su asistencia a la escuela pre-escolar, CSI Head Start opera 3.5 - 8 horas por dia, 5 dias a la semana. Por favor provee un reporte de salud para mi hijo/a usando este formulario. Yo autorizo que proveen informacion medica por forma de este formulario a CSI Head Start.

Signature of Parent, Guardian, or Authorized Representative *Firm del Padre o Guardian* Today's Date *Fecha*

Part B - Physician's Report - To be completed by Physician

EPSDT REQUIRED SCREENINGS

REQUIRED TB RISK ASSESSMENT
MUST BE WITHIN LAST 12 MONTHS
SCREENED, NOT AT RISK ☐
TB SKIN TEST (if applicable)
DATE GIVEN _____
DATE READ _____
MM INDURATION
CHEST X-RAY COMPLETED
_____
RESULTS _____
TREATMENT PLAN _____
_____

HEMOGLOBIN/HEMATOCRIT
HGB _____ HCT _____
IRON PRESCRIBED ☐YES ☐NO
RECHECK DATE _____

LEAD SCREEN (Results from AGE 2)
DATE _____
RESULT _____
TREATMENT PLAN _____
CURRENTLY NOT AT RISK ☐

GENERAL HEALTH
HEIGHT _____ WEIGHT _____
BLOOD PRESSURE _____
URINALYSIS ☐ N/A ☐

VISION RESULTS
PASSED R 20/_____ L 20/_____
FAILED R 20/_____ L 20/_____
UNABLE TO CONDITION ☐
REFERRED TO _____
_____

AUDITORY RESULTS
PASSED R _____ L _____
FAILED R _____ L _____
UNABLE TO CONDITION ☐
REFERRED TO _____
_____

IMMUNIZATION HISTORY - ATTACH A COPY OF CALIFORNIA IMMUNIZATION RECORD

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
GENERAL APPEARANCE	☐	☐	GLANDS	☐	☐
POSTURE/GAIT	☐	☐	HEART	☐	☐
SPEECH	☐	☐	LUNGS	☐	☐
HEAD	☐	☐	ABDOMEN	☐	☐
EYES	☐	☐	GENITALIA	☐	☐
EARS	☐	☐	BONES/JOINTS/MUSCLES	☐	☐
NOSE	☐	☐	SKIN	☐	☐
TEETH Dental Screenig Provided? YES NO	☐	☐	MOTOR SKILLS	☐	☐
BACK	☐	☐	COGNITIVE SKILLS	☐	☐

TOBACCO ASSESSMENT Is child exposed to secondhand smoke? Yes ☐ No ☐
Was counceling about/referred for tabacco use prevention? Yes ☐ No ☐

FOOD ALLERGIES (LIST): _____ ☐ NA

DENTAL SCREENING Did the child receive a visual dental screening? ☐ Yes ☐ No Concerns? Yes ☐ No ☐

DOCTOR'S STAMP (REQUIRED)

COMMENTS *(TREATMENT/RESTRICTIONS/RECOMMENDATIONS FOR SCHOOL)*

List Medications:

PHYSICIAN INFORMATION

I have ☐ have not ☐ reviewed the above information with the parent/guardian

Physician: _____ **Date Physical Exam:** _____

Address: _____ **Date Form Completed:** _____

Telephone: _____ **Signature:** _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner

Crystal Stairs, Inc
Head Start / Early Head Start
Serving our community for more than 30 years
5110 W. Goldleaf Circle, Suite 150
Los Angeles, CA 90056

Individualized Health Care Plan

Participant's parent/guardian has disclosed a medical condition which *requires* special accommodations. Our programs must comply with requests for special needs and any adaptive equipment.

Participant's Name: _____ DOB (Age): _____

Guardian's Name: _____ Telephone Number: _____

MEDICAL CONDITION REQUIRING A SPECIAL ACCOMMODATION: *(CHECK ALL THAT APPLY)*

- ☐ ANEMIA
- ☐ ASTHMA
- ☐ DIABETES
- ☐ EPILEPSY/SEIZURES
- ☐ HEART MURMUR
- ☐ SKIN CONDITION – TYPE: _____
- ☐ SURGERY – TYPE: _____
- ☐ OTHER: _____

DESCRIBE THE DIAGNOSIS, MEDICAL CONDITION, DEVELOPMENTAL ISSUES AND SPECIAL NEEDS:
(YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)

DOES THE CHILD REQUIRE EMERGENCY MEDICATION ADMINISTERED DURING SCHOOL HOURS? ☐ **YES** ☐ **NO**
IF YES, PLEASE LIST:

PRESCRIPTION MEDICATION NAME:	**TRIGGERS:**	**SYMPTOMS:**
DOSE:		
ROUTE:		
TIME:		

LIST ANY SPECIAL EQUIPMENT NEEDED (MAY BE RELATED TO FEEDING, MOBILITY, MEDICATIONS, TOILETING, ETC.):

PROVIDE A BRIEF DESCRIPTION OF RESTRICTIONS THE PARTICIPANT MAY HAVE DUE TO THE MEDICAL CONDITION: *(YOU MAY ATTACH A SHEET WITH ADDITIONAL INFORMATION)*: _____

PLEASE LIST ANY PROCEDURES FOR STAFF TO FOLLOW IN THE EVENT OF AN EMERGENCY: (*YOU MAY ATTACH A SHEET WITH ADDITION INFORMATION):* _____

PRINTED NAME: _____

TELEPHONE NUMBER: _____

DATE: _____

SIGNATURE OF MEDICAL AUTHORITY:

_____

DOCTOR STAMP (REQUIRED)

I hereby give my consent for the Crystal Stairs, Inc. Head Start Program staff to administer the medication listed above to my child during school hours. I understand the medication must be in its original container with my child's name clearly visible.

Yo estoy de acuerdo que el personal del programa de Crystal Stairs, Inc. Head Start administre el medicamento indicado en esta forma a mi hijo(a) durante las horas de escuela. Y entiendo que el medicamento debe de estar en su empaque original con el nombre de mi hijo(a)

PARENT/GUARDIAN SIGNATURE	**PRINTED NAME**	**DATE**

CRYSTAL STAIRS, INC. HEAD START/STATE PRESCHOOL
Serving our families for more than 30 years
Head Start/Early Head Start/State Preschool
5110 W. Gold leaf Circle, Suite 150, Los Angeles, CA 90056 Phone (323)421-1100 * Fax (323) 421-2604

(For parents who are not able to provide a check stub, W2, or 1040 tax form)

Employment Verification Form

(WHITE OUT AND ERASURES ARE NOT ACCEPTABLE ON THIS FORM)

Parent must place signature below to give permission to release this information.

I, hereby, authorize my employer to release to the CSI Head Start/State Preschool program the information requested below.

_____ _____ _____
Parent/Guardian Signature Date Child's Name

_____
Center Name

TO BE COMPLETED BY EMPLOYER:

Name of Employee:_____Job Title:_____

Employer/Business Name:_____

Address:_____ City:_____ ZIP Code_____

Phone:_____

Date of Hire:_____

Days and Hours of Employment:

Sun_____ Mon_____ Tue_____ Wed_____

Thu_____ Fri_____ Sat_____ Overtime:_____ How Often:_____

How are you paid? ☐ Cash ☐ Check ☐ Other _____

If hours of work vary, please attach weekly schedule.

Salary Information: Gross monthly salary $_____ Income earned for last 12 months $_____

Pay Period (Please Check)

☐ Weekly ☐ Monthly

☐ Biweekly ☐ Semi-monthly
Payday every other week ***Same 2 pay periods every month***

The above information pertains to the employee's eligibility for preschool services and is subject to review by the Head Start/Early Head Start representatives.

I affirm that, to the best of my knowledge, the above information is true and correct.

_____ _____ _____ _____
Employer Representative Name Signature Title Date

MUST BE SIGNED BY EMPLOYER

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(Para padres que no pueden proporcionar un talón de cheque, W2, o formulario 1040 de impuestos)

Formulario de Verificación De Empleo

(NO ES ACEPTABLES EL LIQUIDO DE CORRECTOR BLANCO Y BORRONES EN ESTE FORMULARIO)

Los padres deben colocar su firma debajo para dar permiso a liberar esta información.

Por lo presente, yo autorizo a mi empleador a liberar al Programa CSI Head Start/State Preschool la información solicitada abajo.

_____ _____ _____
Firma del Padre/Guardian Fecha Nombre del Nino/a

_____
Center Name

DE SER COMPLETADO POR EMPLEADOR:

Nombre del Empleador: _____ Titulo de Empleo: _____

Nombre de Empleo/Negocio: _____

Domicilio: _____ Ciudad: _____ Código Postal_____

Teléfono: _____

Fecha Contratado:_____

Días y Horas de Empleo:

Dom_____ Lun_____ Mar_____ Mier_____

Jue_____ Vier_____ Sab_____ Horas Extras: _____ Que Tan Seguido: _____

¿Cómo se le paga? ☐ Efectivo ☐ Cheque ☐ Otro _____

Si las horas de trabajo varían, por favor adjunte el horario semanal.

Información del Salario: Salario mensual buto $_____ ingresos en los ultimos 12 meses $_____

Periodo de Pago (Por Favor Indique)

☐ Semanalmente ☐ Mensualmente

☐ Cada 2 Semanas
Día de pago cada dos semanas

☐ Quincenal
Los mismos 2 períodos de pago todos los meses

La información de arriba pertenece a la elegibilidad del empleado para servicios preescolares y es susceptible de ser revisado por los representantes de Head Start/Early Head Start.

Afirmo que, según mi leal saber y entender, la información de arriba es verdad y correcto.

_____ _____ _____ _____
Nombre del Representante de Empleo Firma Titulo Fecha

DEBE SER FIRMADO POR EL EMPLEADOR

ERSEA **(ENTREGUE AL PADRE)** REV. 01/21/14