A **Physical Exam** (Well-Child) and a **Dental Exam** are <u>required</u> by the *Office of Head Start*.

These exams are important to ensure your child's healthy development.

A. Please detach the **Universal Child Health Record** (Physical) and the **Head Start Oral Health** form (Dental).

B. Have your child's *physician* complete the **Universal Child Health Record**

C. Have your child's *dentist* complete the **Head Start Oral Health form**.

D. Return form(s) in-person, fax to (318) 737-2005, or email to enroll@primetimefamily.org.

Have a question? Call (318) 541-2315.

EMAIL to Prime Time Head Start at **enroll@primetimefamily.org** or FAX to **(318) 737-2005**.

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child s Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child s Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

THE NATIONAL CENTER ON Health

Return to Prime Time Head Start
EMAIL to enroll@primetimefamily.org
FAX to (318) 737-2005

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ○ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ○ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ○ No

Are there treatment needs? ☐ Yes, urgent ○ Yes, not urgent ○ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ○ No
X-rays: ☐ Yes ○ No
Risk assessment: ☐ Yes ○ No
Cleaning: ☐ Yes ○ No
Fluoride varnish: ☐ Yes ○ No
Dental sealants: ☐ Yes ○ No

Counseling/Anticipatory Guidance

☐ Yes ○ No

Referral to Specialty Care

☐ Yes ○ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ○ No
Crowns: ☐ Yes ○ No
Extractions: ☐ Yes ○ No
Emergency care: ☐ Yes ○ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ○ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ○ No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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