DOÑA ANA COUNTY HEAD START

Reminder and Release Form for Blood Lead and Hemoglobin/Hematocrit Screen Tests

CHILD: _____ CENTER/Centro: _____ ☐ AM ☐ PM CLASSROOM

REMINDER/Recordatorio #1 DATE/Fecha: _____ #2 DATE/Fecha: _____

REMINDER/Recordatorio #3 DATE/Fecha: _____ #4 DATE/Fecha: _____

Permission for Release of Information / Permiso de Proveer Información

I give permission for the healthcare provider, doctor:_____ to release the requested information to **DAC Head Start** (Health Specialist – 647-8733 ext.123). Doy permiso a mi doctor para dar la siguiente información a **DAC Head Start**. **FAX: 575-647-8734**

Parent or Guardian Signature / Firma:_____

Date / Fecha:_____

Blood Screening

Head Start governing regulation 1304.20-Child Health and Developmental Services

(a) Determining child health status. (1) In collaboration with the parents and as quickly as possible, but no later than 90 calendar days from the child's entry into the program, agencies must: Obtain from a health care professional a determination as to whether the child is up-to-date on a schedule of age appropriate preventive and primary health care. Such a schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT requirements are listed below).

☐ **Blood Lead Screen** (Test) *"To be performed at 12 & 24 months"*

Current Result: _____ Collection Date: _____

☐ **Hemoglobin/Hematocrit** (Test) *"To be performed at 9 & 12 months"*

Current Result: _____ Collection Date: _____

Physician signature: _____ **Date:** _____