THE NATIONAL CENTER ON Health

College of Education
Dona Ana County Head Start, MSC 3R
P.O. Box 30001
Las Cruces, NM 88003-8001
Phone: 575 646-8910 or
Health Specialist: 575- 646-8902

Fax: 575 646-3047

Head Start Oral Health Form-Children

Patient Information

Child's name **Child's date of birth**

This practice is the child's dental home: Yes No Date of Service: _____

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: ____

Permission for Release of Information / Permiso de Proveer Informaci6n

I give permission for the healthcare provider to release the requested information to DACHS.
Yo day permiso a mi doctor para dar la siguiente informaci6n a DACHS.

Parent or Guardian signature/Firma: _____ Date/Fecha: _____

Oral Health Provider's Contact Information and Signature

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

Practice name Address

Provider signature

ENTERED INTO CHILDPLUS
nfA'
By:

This document was prepared under grant#9OHC000S for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Health.

Dona Ana County Head Start FEDERAL REQUIREMENT #1304.20 Physical Exam Form

Parent/Guardian fill this section Padre/Guardian Ilene esta seccion

Child's Name/ Nombre del Niiio: _____ **Sex/ Sexo:** □ **M** □ F

Date of Birth/ Fecha de nacimiento: **Center:** □ AM □PM

How do you pay for health care? Check all that apply:
;,Como paga por el cuidado de la salud? Favor de marcar todo lo que aplique:

□ Medicaid □ Private Insurance / Aseguranza privada □ CHIPS
□ No Insurance/ Sin Aseguranza □ Sliding Scale / Escala de calculo

Permission for Release of Information / Permiso de Proveer Informacion
I give permission for the healthcare provider to release the requested information to DACHS Head Start.
Yo doy permiso a mi doctor para dar la siguiente informacion a DACHS Head Start.

Parent or Guardian Signature / Firma: **Date / Fecha:**

Health Care Providers - please complete sections below

Blood Lead Level: **Collected Date:**

Hgb /HCT: **Collected Date:**

Blood Pressure: **Date:**

Vision: ☐ Pass ☐ Fail ☐ Refer **Hearing:** ☐Pass ☐ Fail ☐ Refer

BMI: <5% WNL >95%

Is the child receiving treatment for:

☐ **Anemia** ☐ **Asthma** ☐ **Overweight** ☐ **High Lead Levels**

☐ **Diabetes** ☐ **Food Allergy** ☐ **Vision Difficulties** ☐ **Hearing Problems**

☐ **Other:** please indicate severity and treatment. _____

Does the child need a follow-up appointment? ☐Yes ☐ No **Date of follow-up?** ____/____/____

If so, please indicate:

Any Concerns? ☐ Yes ☐ No

Is this child up-to-date on the EPSDT schedule? ☐ Yes ☐ No

Is the Medicaid periodicity schedule being followed? ☐ Yes ☐ No

Immunization Status: **D** Up-to-date **D** Catch-up-schedule **Patient Needs:**

Physical Examination Completed by: (please print name) _____

Exam Date:

Phone: **Fax:** **Sie;nature:**

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BY: _____

DATE: _____