

**Family Development Services**  
**Head Start Program**  
3637 N Meridian St., Indianapolis, IN 46208  
Telephone: (317) 803-3803

Dear Medical/Dental Provider,

The following information is needed on each child for enrollment in the Head Start Program – Marion and Hamilton Counties. We appreciate the time and efforts required to fill out our forms, but the Federal Government requires us to gather this information. Please fill the forms out in the following manner:

- Blue Forms = Doctor/Medical Provider
- Green Form = Dentist
- Purple Form = Doctor/Medical Provider

**Head Start MEDICAL REQUIREMENTS:**

A complete physical examination with recording of all body regions, documenting any allergies or abnormalities.

Please include the following screens:

- Height & Weight Measurements
- Hgb/Hct Levels
- Vision Screen
- Lead Screen

**IMMUNIZATION RECOMMENDATIONS:**

- 4 – Diphtheria/Pertussia/Tetanus (DPT)
- 3 – Oral PolioVaccine (OPV/IPV)
- 1 – Measles/Mumps/Rubella (MMR)
- 4 – Haemophilus Influenzae type b (HIB)
- 3 – Hepatitis B
- 4 – Pneumococcal (for children who began the series at 23 mo & younger)
- 1 – Varicella

NOTE: Family Development Services follows the minimum Immunization requirement set forth by the State Board of Health.

**DENTAL RECOMMENDATIONS:**

A dental examination, cleaning, and fluoride treatment.

NOTE: -If restoration, pulp therapy, and/or extractions are needed, please document need on the Oral Health Form

-Please record all work that has been done and sign the bottom of the Oral Health Form

---

Thank you for helping us provide much needed Medical/Dental services to our families. If you have low income patients with 3, 4, or 5 year old children that could benefit from a quality Early Childhood Development Program, please don't hesitate to refer them.

Sincerely,

Kimberly Hagler-Rhodes: Head Start Director

**Family Development Services/Head Start Physical Exam-Child**  
 3637 N Meridian St., Indianapolis, IN 46208 (317) 803-3803

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child Name: \_\_\_\_\_  
First Last

Child's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Setting:  Home  Doctor Clinic  School/Center  Employment  Other: specify

Completed By: Medical Provider:

<u>Physical Exam/Assessment</u>	Normal	Abnormal	Referred	Not Evaluated
Other Conditions (list) _____				
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posture, Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes External Aspects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optic Fundoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears External Canal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose, Mouth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen (including hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bones, Joints, Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological/Social	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-help Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glands (Lymphatic/Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Family Development Services, Head Start Oral Health Assessment

2008-2009

THIS SECTION IS TO BE COMPLETED BY THE PARENT

CHILD'S BIRTHDATE: \_\_\_\_\_

Date Completed:  /  /

Child's Name:

Gender:  Male  Female

Head Start Center:

Phone:  (317) 803-3817 or 803-3816

Address:  Family Development Services, Head Start – 3637 N Meridian Street – Indianapolis, IN 46208

Is the child now receiving any of the following:

Topical Fluoride Application  Fluoridates Water

Fluoride Supplement Diet: Tablets  Fluoride Supplement Diet: Liquid

If yes, how long:

Does the child have any trouble with teeth, gums, or mouth that the parent knows about:

Yes: Specify   No

Has the child previously seen a dentist:  Yes  No

If yes, Dentist name:

Date Visited:  /  /

Is child currently under a physician's care:  Yes  No

If yes, Physician's name:

Is the child currently taking any medication:  Yes  No Type:

Child is reported to have:

Allergies

Asthma

Bleeding

Diabetes

Epilepsy

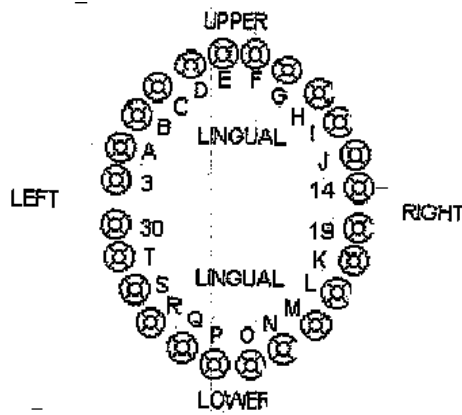
Heart/Vascular Disease

Liver Disease

Rheumatic Fever

Check Box 34

Other: Specify



**Key:**  Missing  Decayed  Filled

Type of Assessment:  Screening  Assessment

Flossing Frequency:  Daily  Weekly  Occasionally  Never

Number of times per day child brushes teeth:

Gum Condition:  Normal  Swollen  Bleeds easily  Infected

Dental Needs:  No needs  Treatment  Cleaning  
 Fluoride Supplement  Oral Hygiene Instruction  
 Other: Specify

**Child Oral Health Summary:**

All planned treatment complete:  Yes  No: If not, explain below and check items

Routine recall visits  Dietary Problem(s)  
 Harmful oral habits  Special home emphasis  
 Developmental problem(s)  Needs Fluoride supplement  
 Oral Hygiene

**Source of Reimbursement of services:**

EPSDT/Medicaid  Federal, State, or other agency  Head Start  In-Kind Provider  
 Parents/Guardians  Other (3<sup>rd</sup> party)

Priority Group:  A. Needs attention Immediately  B. Needs attention soon  Needs routine care

**Comments:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that I completed the services needed and that itemized charges do not exceed my usual and customary fees:

Provider's Name/Address: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_