



Family Development Services  
— A Head Start Organization —

## MEDICAL AND DENTAL INSTRUCTIONS

In order to successfully enroll your child into the Head Start program, Family Development Services is required to gather certain pieces of information about your child and your family. All of the information we gather is considered to be confidential and is secured in our electronic information system. By this request, we can provide better services for your child and the family.

This packet is divided into 4 color-coded parts. They are to be completed using the following format:

Green =	Completed by Dentist
Blue =	Completed by the Doctor/Primary Care Provider
Purple =	Completed by the Doctor/Primary Provider if your child has Asthma
Yellow =	Completed by the Doctor/Primary Provider if your child has a Food Restriction

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After your child has completed the physical and dental exams, please contact one of the school's listed on the back of this form and schedule an appointment to complete the enrollment process with an Intake Worker.

### YOU MUST BRING THE FOLLOWING ITEMS TO THE INTAKE APPOINTMENT:

1. Original/Official Birth Certificate of the child you are enrolling
2. Medicaid card/ Hoosier Healthwise card
3. Insurance Card (if Private)
4. Social Security Cards for Child, Head of Household, and other Parent/Guardian
5. Evidence of Income:
  - a. Submit 1040 tax form (1<sup>st</sup> two pages); Wage History Report, 2009 W-2 forms;
  - b. Public Assistance Letter; Social Security Income; Unemployment Verification; or Verification of your wages signed by your employer,
  - c. Documentation of Child Support payments, Foster Care and/or Adoption Subsidy
6. Proof of Employment Training (if applicable)
7. If your child has been diagnosed with a Special Need or Physical Disability, please bring a copy of your child/s most recent IEP or IFSP from the School District.
8. Five (5) emergency numbers: Name, Address, and Telephone number of a relative, friend, or neighbor that does not live in the home.
9. Hoosier Works Card (Food Stamp Debit Card)
10. An up-to-date **Physical/Dental** with a current shot record (immunizations)

**\*These documents must be submitted to us to fully evaluate your application.**  
**APPOINTMENTS ARE LIMITED, IF YOU CANNOT MAKE YOUR APPOINTMENT, PLEASE CALL THE SCHOOL AS SOON AS POSSIBLE TO CANCEL OR RE-SCHEDULE YOUR APPOINTMENT.**



## Family Development Services

— A Head Start Organization —

**3637 N. MERIDIAN STREET. INDIANAPOLIS, INDIANA 46208**  
**(T) 317 803-3803 (F) 317 803-4490**

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 agency 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 Forms = Dentist  
\*Purple Forms = Doctor/Medical Provider  
\*Yellow Forms = Doctor/Medical Provider

### **\*HEAD START MEDICAL REQUIREMENTS:**

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

Please include the following screenings:

Height and Weight Measurements  
Vision Screen

Hgb/Hct Levels  
Lead Screen

### **\*IMMUNIZATION RECOMMENDATIONS:**

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

**Note:** Family Development Services follows the minimum Immunization requirements set forth by the State Board of Health.

### **\*DENTAL REQUIREMENTS:**

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 (Green Form)

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

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Thank you for helping us provide much needed Medical/Dental services to our families. If you have low-income patients with 3-5 year old children that could benefit from a quality Early Childhood Development Program, please do not 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

2010-2011

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

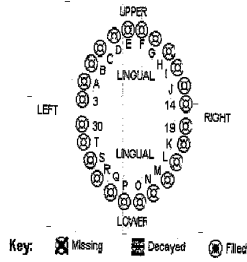
Heart/Vascular Disease

Liver Disease

Rheumatic Fever

Check Box 34

Other: Specific



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: \_\_\_\_\_