



Family Development Services  
— A Head Start Organization —

**3637 N. MERIDIAN STREET. INDIANAPOLIS, INDIANA 46208**  
**TELEFONO 317-803-3803 FAX 317-803-4490**

**Querido Proveedor Medico/Dental:**

La siguiente información es necesaria para matricular a los niños en el programa Head Start, de los Condados de Marion y Hamilton. Nosotros le agradecemos su tiempo y esfuerzo por llenar las formas que necesitamos, pero el Gobierno Federal requiere que nosotros tengamos esta información. Por favor llene las formas de la siguiente manera:

Blanco = Papeles para el Dentista  
Blanco = Por el Doctor/Proveedor de Cuidado  
Morado = Por el Doctor/Proveedor de Cuidado si su hijo tiene Asma.  
Amarillo= Por el Doctor/Proveedor de Cuidado si su hijo si su hijo tiene Alergias o Restricciones a ciertos alimentos.

**\*REQUERIMIENTOS MEDICOS DE HEAD START:**

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Un examen físico completo y examen de todas las partes del cuerpo, documentando cualquier alergia, intolerancia y/o anomalías.

Medidas de Peso y Altura  
Examen de la Vista

Niveles de Hg/Hct  
Examen del Plomo

**\*RECOMENDACION DE INMUNIZACION:**

- 4- Difteria/Percusia/Tétanos (DPT)
- 3- Vacuna Oral Polio (OPV/IPV)
- 1- Measles/Mumps/Rubeola (MMR)
- 4- Haemophilus Influenza tipo b (HIB)
- 3- Hepatitis B
- 4- Pneumococcal (para los niños que empezaron las series a los 23 meses o más pequeños)
- 1- Varicela

**Nota:** Family Development Services Sigue las Inmunizaciones que son requeridas por el Departamento de Estado de Salud.

**\*DENTAL REQUIREMENTS:**

Un examen Dental, limpieza y tratamiento de fluoruro.

Nota: -Si la restauración, tapada de muelas, y/o extracciones son necesarias por favor documéntelo en Forma de Salud Dental (Forma Verde)

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Muchas gracias por ayudarnos ha proveer los servicios Médicos /Dentales a nuestras familias. Si usted tiene pacientes de 3-5 años y son de bajos recursos económicos, que se puedan beneficiar de un Programa de Educación Pre-Escolar de buena Calidad, por favor refiéralos a nuestro programa.

Sinceramente  
Kimberly Hagler-Rhodes: Directora de Head Start

**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

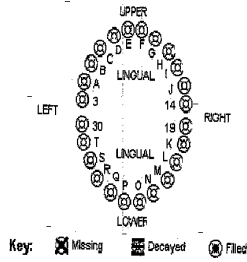
Heart/Vascular Disease

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: \_\_\_\_\_