FAMILY DEVELOPMENT SERVICES HEAD START WELL CHILD EXAM

Client Name _____ Date of Birth: _____

Date of Exam _____

Examination: Height, Weight, BP, Vision, HGB, Lead MUST BE COMPLETED

Height: **Weight:** **BP:** / **Hgb/Hct:**

Vision: R Pass/Fail **L Pass/Fail** **Lead:**

	Normal	Abnormal Findings	Not Examined
Appearance	☐	☐	☐
Posture, Gait	☐	☐	☐
Head	☐	☐	☐
Skin	☐	☐	☐
Eyes External Aspects	☐	☐	☐
Optic Fundoscope	☐	☐	☐
Cover Test	☐	☐	☐
Ears Internal Aspects	☐	☐	☐
Ears External Aspects	☐	☐	☐
Nose, Mouth, Pharynx	☐	☐	☐
Teeth	☐	☐	☐
Heart	☐	☐	☐
Lungs	☐	☐	☐
Abdomen (include Hernia)	☐	☐	☐
Bones, Joints, Muscles	☐	☐	☐
Neurological/Social	☐	☐	☐
Gross Motor	☐	☐	☐
Fine Motor	☐	☐	☐
Communication skills	☐	☐	☐
Cognitive	☐	☐	☐
Self-help skills	☐	☐	☐
Social skills	☐	☐	☐
Glands (Lymphatic/Thyroid)	☐	☐	☐
Muscular coordination	☐	☐	☐

Medical Conditions: Additional documentation/follow-up is required for the items selected below

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medications ☐ Pollens ☐ Food ☐ Stinging Insects

Medications and Allergies: Please list all prescription and over-the-counter medications that you are currently taking. Over-the-counter medications must have a prescription to be able to be given at school.

Medical Conditions: Additional documentation/follow-up is required for the items selected below

☐ Anemia ☐Asthma ☐Cerebral Palsy ☐ Convulsions/Seizure Disorder(without fever) ☐ Diabetes ☐ Failure to Thrive

☐ Epilepsy/Seizure Disorder ☐ Feeding/Eating Problems ☐ Gastro-intestinal Disturbance ☐ Heart Problem

☐High Lead ☐Hearing Problems ☐ Respiratory Disorder ☐ Chronic Lund Disease ☐Vision Problems ☐ Other: _____

Comments:

Name of physician (print/type) Date

Address Phone

Signature of physician

Head Start
Student Dental Health Form

Student Name: _____ **Date of Birth:** _____

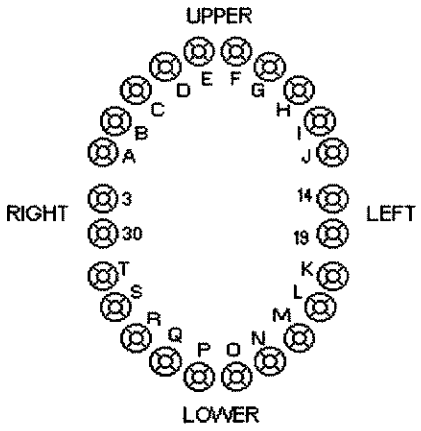
Dental Provider Signature: _____

Dental Provider: _____

Date of Exam: _____

Type: ○ Examination

ORAL CONDITION



Missing
Decayed
Filled

Flossing Frequency:

○ N/A ○ Never ○ Daily ○ Weekly ○ Occasionally

Gum Condition:

☐ Normal ☐ Swollen ☐ Infected ☐ Bleeds Easily

Dental Needs:

☐ Preventative Services ☐ Dental Treatment*

Dental Services Received:

☐ Preventative Services Received*
☐Bitewing Films ☐Cleaning ☐ Fluoride Supplement
☐Fluoride Varnish ☐Oral Hygiene Instruction ☐Sealants
☐Other(Please explain)_____

☐ Dental Treatment Received*
☐ Extraction ☐ Pulp Therapy
☐ Other (Please explain)_____

☐ Restoration
☐ Extraction

☐ Treatment Not Received*
☐ Reason for no dental treatment*_____

Provider Setting:

☐ Doctor/Clinic ☐ Home ☐ Employment ☐ School ☐ Other _____

# of Times Per Day Child Brushes Teeth: _____

Comments: _____

_____

_____

Family Development Services
3637 N. Meridian St.
Indianapolis, IN 46208
(317)803-4490 FAX (317)803-4490

Individual Health Plan

Child Name: _____ Date of Birth: _____

INSTRUCTIONS: *This form is used by the Health Coordinator, in collaboration with parent(s), to identify follow-up/support needed for an individual child's health issue (e.g., as identified by a physician). This form goes in child's file; in child's classroom and also documented in Promis as Individual Health Plan.*

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Education Rights and Privacy Act, I hereby authorize _____ (Provider Name) to release such protected health information of my child as necessary for the specific purpose of completing the Health Plan. I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with Family Development Services. This permission to release may be cancelled at anytime. This information is to be released for the specific purpose of health care planning. The undersigned certifies that he/she is the parent or guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Signature of Parent or Guardian: _____ Date: _____

BOXES CANNOT BE LEFT BLANK

Health Concern *(Please describe)*	
Signs/Symptoms *(What should staff be alerted to?)*	
Treatment/Medication *(Current treatment plan)*	
Accommodations Needed *(Restricted activity, dietary restrictions- include foods to be omitted and foods to be used as substitution, environmental control)*	
Emergency Drills (*Special accommodations during emergency (Fire, tornado) drills*	

Emergency Situation	In the event of an emergency I consent for Head Start to call 911 and my child be transported to the nearest hospital?	❑ Yes ❑ No

Medication	Does child currently take medication for this condition?	❑ Yes ❑ No	**Requires Medication Authorization form.*
	If so, will medication need to be administered at our center?	❑ Yes* ❑ No	

Training Needs	Is specialized training necessary for classroom staff?	❑ Yes ❑ No

Providers Name **Address** **Phone Number** **Fax Number**	

Physician Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Print Name:_____ Relationship to Child:_____

Staff Name/Signature:_____ Date:_____

ASTHMA MANAGEMENT PLAN & AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Patient's Name _____ Date of Birth _____ School _____ Grade_____

☐ School E-mail _____ ☐ School Fax (___) _____

Parent/Caregiver _____ Phone (H) _____ Phone (W) _____

Phone (Cell) _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Asthma Care Provider _____ ☐ Office Phone (___) _____

☐ Office E-mail _____ ☐ Office Fax (___) _____ (please mark best contact)

TO BE COMPLETED BY ASTHMA CARE PROVIDER

RESCUE (quick-relief) MEDICATION: _____

MONITORING	TREATMENT
RED **RED ZONE: EMERGENCY SIGNS** • Lips and fingernails are blue or gray • Trouble walking and talking due to shortness of breath • Loss of consciousness **RED ZONE: DANGER SIGNS** • Very short of breath, or • Rescue medicines have not helped, or • Cannot do usual activities, or • Symptoms are same or get worse after 24 hours in Yellow Zone	• Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min between puffs) or 1 nebulizer treatment • **Call parent and/or Asthma Care Provider** • **Call 911 NOW if:** 1. Unable to reach medical care provider after arriving in the red zone 2. Child is struggling to breathe and there is no improvement after taking albuterol 3. May repeat rescue medication every 10 minutes if symptoms do not improve, until medical assistance has arrived or you are at the emergency department
YELLOW **YELLOW ZONE: CAUTION** • Cough, wheeze, chest tightness, or shortness of breath, or • Waking at night due to asthma, or • Can do some, but not all, usual activities	• Continue daily controller medications • Give rescue medication: ☐ 2 ☐ 4 ☐ 6 puffs (1 min between puffs) OR 1 nebulizer treatment every 4 hours as needed • Wait 10 minutes and recheck symptoms • **If not better, go to RED ZONE** • **If symptoms improve, may return to class or normal activity, or** _____ • **Parent/School Nurse:** If needed, coordinate rescue medications to be given every 4 hours for ☐ 2 ☐ 3 days, if symptoms remain improved • If symptoms are not gone after ☐ 2 ☐ 3 days, move to the RED ZONE
GREEN **GREEN ZONE: WELL** • No cough, wheeze, chest tightness, or shortness of breath during the day or night • Can do usual activities	

MEDICATION	HOW MUCH	WHEN
		Before Exercise ☐ Recess ☐ PE/Sports *(not to exceed every 4 hours)*
DAILY CONTROLLER MEDICATION	**HOW MUCH**	**WHEN**

☐ Administer medications as instructed above

☐ Student has been instructed in the proper use of all his/her asthma medications, and in my opinion, the student can carry and use his/her inhaler at school

☐ Student needs supervision or assistance to use his/her inhaler medication

☐ Student should NOT carry his/her inhaler while at school ☐ Have student use spacer with inhaler medication

_____ _____ _____

ASTHMA CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER NAME** **DATE**

I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my asthma care provider if necessary and for this form to be faxed/emailed to my child's school or be shared with school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices.

_____ _____

PARENT SIGNATURE **DATE**

Family Development Services

A Head Start Organization

SEIZURE ACTION PLAN

Student Name: _____ DOB: _____ Phone: _____

Seizure History: Type: _____ Frequency: _____

Duration: _____ Date of last seizure: _____

Medication (name and dosage): _____

Does child experience an aura prior to seizure? Yes___ No___ If so, describe:_____

_____

Procedure:

1. If child is on the bus when seizure occurs, pull bus over to side of road.
2. Have one adult stay with child, while the other adult calls 911.
3. If needed, move other children to another area of the center.
4. Move child to flat surface out of danger.
5. Provide an open airway for child: turn child on side to let saliva drain.
6. Do not try to interrupt the seizure.
7. Gently support the child's head and keep the child's hand from injuring him/herself but do not restrain.
8. *Do not put anything in child's mouth*.
9. Reduce external stimuli (other children, lights, music).
10. Loosen tight clothing.
11. Record seizure activity on accident report.

Special instructions:

_____

_____

Parent's signature_____ Date _____

Physician's signature_____ Date _____ Phone Number: _____

STATEMENT OF IMMUNIZATION HISTORY; WAIVER; RULES - INDIANA CODE §20-34-4-5

(a) Each school shall require the parent of a student who has enrolled in the school to furnish **not later than the first day of school** a written statement of the student's immunization, accompanied by the physician's certificates or other documentation, unless a written statement of this nature is on file with the school.
(b) The statement must show, except for a student to whom IC 20-34-3-2 or IC 20-34-3-3 applies, that the student has been immunized as required under section 2 of this chapter. The statement must include the student's date of birth and the date of each immunization.

VACCINATION EXEMPTION PURSUANT TO INDIANA CODE §20-34-3-2

(a) Except as otherwise provided, a student may not be required to undergo any testing, examination, immunization, or treatment required under this chapter or IC 20-34-4 when the child's parent objects on religious grounds. A religious objection does not exempt a child from any testing, examination, immunization, or treatment required under this chapter or IC 20-34-4 unless the objection is:
(1) made in writing;
(2) signed by the child's parent; and
(3) delivered to the child's teacher or to the individual who might order a test, an exam, an immunization, or a treatment absent the objection.

VACCINE EXEMPTION FORM

I,_____, as the parent, guardian or person in
(insert your name)
loco parentis of the child _____, hereby certify that the
(insert your child's name)
administration of any vaccine or other immunizing agents is contrary to our

personal religious beliefs.

☐	Diphtheria	☐	Varicella
☐	Tetanus	☐	Hepatitis B
☐	Pertussis	☐	Hepatitis A
☐	Polio	☐	Meningitis (MCV4)
☐	Measles	☐	Meningitis B
☐	Mumps	☐	Other:
☐	Rubella	☐	

This is pursuant to my right to refuse vaccination on the grounds that vaccinations conflict with my religious beliefs. Pursuant to Indiana statute I am providing a copy of this statement to our child's school administrator or operator of the group program pursuant to IC § 20-34-3-2.

Parent/Guardian _____ Date _____

FARE Food Allergy & Anaphylaxis Emergency Care Plan

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

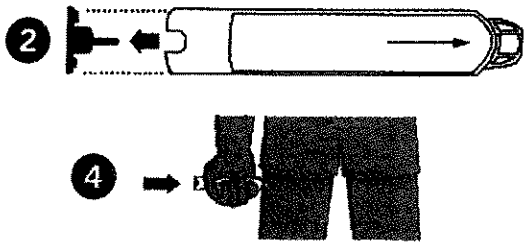
PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

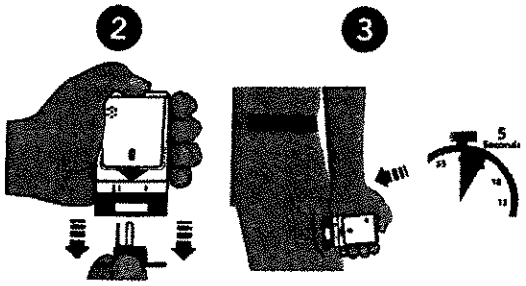
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



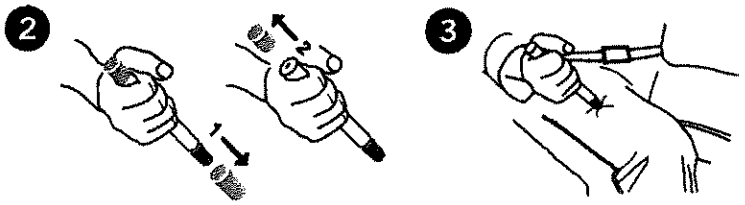
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____ DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

Family Development Services

A Head Start Organization

Non-Food Allergy Action Plan

Student Name: _____ DOB: _____ Center: _____

Health records note an allergy to: _____

☐ **My child is no longer allergic**	**Parents Signature:** _____	**Date**_____

Symptoms student has experienced in the past: (please check all that apply)

___ Localized swelling ___ swelling of lips, tongue, throat ___ Hives

___ Breathing difficulty ___ Wheezing ___ Nausea

___ Hoarseness ___ Thickened speech ___ Dizziness

___ Weakness ___ Abdominal cramps ___ Itching

___ Flushed skin ___ Blue color of skin/lips ___ Anxiety

___ Other (explain) _____

Medication	**Dosage**	**Give**
		___**Immediately** ___**If symptoms arise**
		___**Immediately** ___**If symptoms arise**

*If epipen/twininject is administered, **911** must be called

Parent/Guardian Responsibility:

- Send all required medication in the original container, medication must be current. (not expired)
- This form must be signed by the physician/parent & returned to the Family Advocate/Family Support Specialist
- Inform your Family Advocate/ Family Support Specialist, in writing, of any changes in medication orders

_____ (___)_____ _____

Parent Signature Phone Number Date

_____ (___)_____ _____

Physician Signature Phone Number Date

Family Development Services, A Head Start Organization

Special Dietary Needs Form

Complete and submit this form to **Family Development Services**. The parent/guardian/adult participant will complete part 1 and 2, and the physician or medical authority (physician's assistant or nurse practitioner) will complete part 3. Refer to the information below for clarification. Attach a sheet with additional information if necessary. If changes are needed, the parent/guardian/adult participant is required to submit a new form.

GUIDANCE

Disability:

USDA requires substitutions or modifications in CACFP meals for participants whose disabilities restrict their diets. The definition of the term "disability" has broadened and nearly all physical and mental impairments constitute a disability.

Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, and Departmental Regulations at 7 CFR Part 15b define a person with a disability as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment. (See 29 USC § 705(9)(b); 42 USC § 12101; and 7 CFR 15b.3.) "Major life activities" are broadly defined and include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. "Major life activities" also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. (See 29 USC § 705(9)(b) and 42 USC § 12101.)

A physical or mental impairment does not need to be life threatening to constitute a disability. It is enough that the impairment limits a major life activity. Further, an impairment may be covered as a disability even if medication, or another mitigating measure, may reduce the impact of the impairment.

Forms or medical statements for disabilities must be signed by a licensed physician, physician's assistant or nurse practitioner and must identify: the child's medical condition; an explanation of why the disability restricts the child's diet; the major life activity affected by the disability; the food or foods to be omitted from the child's diet, and the food or choice of foods that must be substituted.

Special Dietary Needs That Are Not a Medical Condition:

Food service may make food substitutions, at their discretion, for individual children who do not have a disability/medical condition, but who have special dietary needs for other reasons such as religious, cultural, or other preferences. CACFP participating organizations are encouraged to accommodate reasonable requests, but are not required to do so. For these requests, the form may be signed by a parent/guardian/adult participant.

The form should include: an identification of the special dietary need that restricts the diet; the food or foods to be omitted; and the food or choice of foods to be substituted.

Part 1. To be completed by a Parent, Guardian, or Authorized Representative		
Participants' Name:		Birthdate: / /
Parent/Guardian/Authorized Representative name:		
Home Phone: ( )	Work Phone: ( )	
Address:		
City:	State:	Zip:

Part 2. Special Dietary Need that is not a Medical Condition

Describe the participant's special dietary need:

Foods to be omitted:	**Substitutions:**

Please list additional information regarding the diet:

Parent/guardian/adult participant/rep. of adult participant signature	**Date**

Part 3. Disability/Medical Condition

Describe the patient's medical condition and the major life activities that are affected:
****If this is a Food Allergy a Food Allergy Action Plan is required to be completed in addition to this form.****

Foods to be omitted:	**Substitutions:**

Please list additional information regarding the diet (including texture changes such as chopped, ground, pureed, etc.):

Licensed physician, physician's assistant or nurse practitioner signature	**Date**
Printed name and title	**Telephone**