www.myheadstart.org

SANTA CLARA COUNTY OFFICE OF EDUCATION
Early Learning Services Department - Head Start Program
1290 Ridder Park Drive, MC 225
San Jose, CA 95131-2304

1 (408) 453-6900 or 1 (800) 820-8182

Dear Parent,

Thank you for your interest in the Head Start Program. We provide full day and part day preschool services, free of charge, to eligible families who live in Santa Clara and San Benito Counties. We also offer home-based and center based services for newborn children to 36 months. Please fill out the application completely and if you need help you can call us at (408) 453-6900 or (800) 820-8182, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Please note that as part of the enrollment process, you will have an interview with a Head Start Staff.

DOCUMENTS YOU WILL NEED (Copies only, these will not be returned)

- ☐ **Income Verification** – The documents need to show your income **for the past 12 months**. All parent's or guardian's income needs to be submitted. This includes:
  - **Pay Stubs for the past 12 Months,** or pay stubs in combination with:
    - **Latest Income Tax Return (1040) or W-2**
  - **Notice of Action** (if receiving CalWORKs)
  - **Proof of SSI (Supplemental Security Income)** (if applicable)
  - **Unemployment Income** (if applicable)
  - **Worker's Compensation** (if applicable)
  - **Child Support** (if applicable)
  - **Disability Income** (if applicable)
- ☐ **Birth Certificate**
- ☐ **Proof of Legal Custody** (if the child is in foster care)
- ☐ **Homeless Verification** (if applicable and if available)
- ☐ **Immunization Records**
- ☐ **TB Assessment or TB Test Results**
- ☐ **Current IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan)** (if applicable)
- ☐ **Full Time Employment or School/Training Verification** (if you would like full day services)

SCHEDULE YOUR INTERVIEW

When you have gathered your documents and completed your application**, call (408) 453-6900.** A Head Start Staff will call you back to schedule a date and time for an interview at a location near you. Please be sure to bring all the documents listed above and the completed application.

Please call 1 (408) 453-6900 or 1 (800) 820-8182 to schedule your interview

HeadStart™
OF SANTA CLARA AND SAN BENITO COUNTIES

CPID #________________

ENROLLMENT APPLICATION

PLEASE PRINT LEGIBLY USING BLACK OR BLUE INK ONLY

I would like to apply for: ☐ AM Session ☐ PM Session ☐ Full Day* ☐ No Preference

*Note: Full day requires both parents/guardians must be working full time more than30 hours per week or in school full time taking 12+ units

Child (Applicant)

First Name	Last Name	Middle	Gender ☐ Male ☐ Female	Birth Date / /
Living Address		City/ Zip		Birth Country
Mailing Address (if different)		City/ Zip		

Is the child in foster care? ☐ Yes ☐ No

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic / Non-Latino

Race ☐ Asian ☐ White (European, Middle Eastern, North African) ☐ Black/African American ☐ Pacific Islander / Hawaiian ☐ American Indian/Alaskan ☐ Some Other Race (Bi-racial/Multi-racial; Mexican; Puerto Rican) ________________

Does the child have a current IEP or IFSP? ☐ Yes ☐ No If yes, please complete the Disabilities section of this application

Family Information

Primary Language Spoken at Home ☐ English ☐ Spanish ☐ Vietnamese ☐ Other ____________________________

What language would you like to receive written information? ☐ English ☐ Spanish ☐ Vietnamese

Does the child (applicant) have a sibling with a current IEP or IFSP? ☐ Yes ☐ No

Name of Person(s) Having Legal Custody of the Child	Parents/Guardians in the Home ☐ One Parent ☐ Two Parents	Primary Email Address

Mother/Guardian's Name	Birth Date	Relationship to Child

Lives with the Child ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Primary Phone Number ☐ Cell ☐ Home ☐ Work ☐ Other

Employment Status ☐ Employed ☐ Seasonally Employed ☐ Retired ☐ Unemployed ☐ Seeking Employment ☐ Student ☐ Disabled ☐ Incapacitated From _______ to _______

Mother/Guardian's Email Address

Alternate Phone Number ☐ Cell ☐ Home ☐ Work ☐ Other

Education ☐ Less than High School ☐ Some College or AA/AS ☐ High School Grad or GED ☐ Bachelor's or Advanced Degree

Father/Guardian's Name	Birth Date	Relationship to Child

Lives with the Child ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Primary Phone Number ☐ Cell ☐ Home ☐ Work ☐ Other

Employment Status ☐ Employed ☐ Seasonally Employed ☐ Retired ☐ Unemployed ☐ Seeking Employment ☐ Student ☐ Disabled ☐ Incapacitated From _______ to _______

Father/Guardian's Email Address

Alternate Phone Number ☐ Cell ☐ Home ☐ Work ☐ Other

Education ☐ Less than High School ☐ Some College or AA/AS ☐ High School Grad or GED ☐ Bachelor's or Advanced Degree

List all other family members living in the household for whom you are responsible for the care and welfare - NOT LISTED ABOVE:

First Name	Last Name	Date of Birth	Is this person related to the child's parent(s)?	Is this person supported by the parent'(s) income?
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No

Total number of people living in the household (including you) for whom you provide financial support ☐

HEAD START ENROLLMENT APPLICATION

Child's Name ______________________ **Birth Date** ______________

Emergency Contact Information

Name	Phone	Relationship

Family Residency

Temporarily in one of the following due to inadequate housing, financial hardship, or loss of housing

Family Living Situation (Check all that apply)

- ☐ Shelter Name ______________
- ☐ Motel/Hotel Name ______________
- ☐ Transitional Housing Name ______________
- ☐ Single Room Occupancy (SRO)
- ☐ Car, Trailer, or Campsite
- ☐ Rented Garage
- ☐ Rented Trailer, Motor Home on Private Property
- ☐ With another adult (Not the parent/legal guardian)
- ☐ Another Family's House/Apartment
- ☐ None of the options apply
- ☐ Other (Not designed for human beings)
  Explain: ______________________

Eligibility

Mother/Guardian

Mother Name	Has Income ☐ Y ☐ N

Check all that apply

Do you receive: Monthly Amount

- ☐ TANF/CalWORKs $ __________
- ☐ SSI $ __________
- ☐ Child Support $ __________
- ☐ Other sources of income $ __________
  ____

Employment Information

Employer Name	Employer Phone
Employer Name	Employer Phone

Pay Periods ☐ Weekly ☐ Every 2 Weeks ☐ Twice Per Month ☐ Monthly

Gross Income $ __________ Per __________

School/Training Information

Are you in School or Training? ☐ Yes ☐ No

School Name	School Phone

School Units __________

Father/Guardian

Father Name	Has Income ☐ Y ☐ N

Check all that apply

Do you receive: Monthly Amount

- ☐ TANF/CalWORKs $ __________
- ☐ SSI $__________
- ☐ Child Support $__________
- ☐ Other sources of income $ __________
  ____

Employment Information

Employer Name	Employer Phone
Employer Name	Employer Phone

Pay Periods ☐ Weekly ☐ Every 2 Weeks ☐ Twice Per Month ☐ Monthly

Gross Income $ __________ Per __________

School/Training Information

Are you in School or Training? ☐ Yes ☐ No

School Name	School Phone

School Units __________

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing childcare services.

Parent/Guardian's Signature ______________________ **Date** ______________

Laserfiche Only

AN INCOMPLETE APPLICATION WILL DELAY ENROLLMENT

REVIEW ANNUALLY WITH PARENTS/GUARDIAN'S

Child's Name ____ **Birth Date** _____________________

HEALTH HISTORY INFORMATION				
Doctor's Name (Medical Home)	Phone ( )	Address	City	Zip
Dentist's Name (Dental Home)	Phone ( )	Address	City	Zip

Health Coverage: ☐ Medi-Cal/Medicaid ☐ California Healthy Kids ☐ Private ☐ Other_______________________________

Dental Coverage: ☐ Medi-Cal/Medicaid ☐ California Healthy Kids ☐ Private ☐ Other_______________________________

Are you receiving services from WIC? ☐ Yes ☐ No | **Do you have health insurance for yourself/family?** ☐ Yes ☐ No

IMMUNIZATIONS

Before your child is placed on a class list, copy of your child's current immunization records must be received by the program according to the State of California Immunizations requirements. All immunizations must be recorded by showing a date given and signature or stamp verification by health care provider. If your child does not have an immunization record or has not received all required immunizations, call your health care provider as soon as possible to obtain a record or make an appointment for your child to receive these immunizations.

REQUIRED HEALTH ASSESSMENT (PHYSICAL EXAM)

A health assessment (physical examination) by a physician is required. This exam should include Hemoglobin/Hematocrit (blood work) at 12 months and older if at risk, Hearing and Vision Screenings, Height & Weight, TB Assessment and/or test if at risk, Lead Assessment/Blood Test. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor within 30 days of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Child Health Assessment form).

Is a copy of a current Physical Exam included with application? ☐ Yes ☐ No Date of child's last physical exam _________________

REQUIRED DENTAL EXAM (CHILDREN AGES 1-5 YEARS OLD)

A dental exam by a dentist is required starting at 12 months. If you do not have a copy of a current dental exam for your child, you will be asked to take your child to the dentist within 90 days of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Dental Examination form).

Is a copy of a current Dental Exam included with application? ☐ Yes ☐ No Date of child's last dental visit ___________________

MEDICATIONS

LIST ALL MEDICINES, PRESCRIPTIVE AND NON-PRESCRIPTIVE, THAT YOUR CHILD TAKES REGULARLY

Will your child need to have medication at school ☐ Yes ☐ No

Your child will not be given medication at school without a physician's note and a Classroom Health Plan written with the parent and program staff.

ALLERGIES AND SPECIAL DIETS

CIRCLE ONE

LIST ALL ALLERGIES (FOOD OR OTHER)

Has your child been prescribed medication for an allergic reaction? **Yes** **No**

List special diets to accommodate for cultural preference or for religious or medical reasons (indicate what specific foods are included)

A Classroom Nutrition Plan will be written with the parent and program staff to address all allergies and special diets.

NUTRITION

Does your child experience any of the following symptoms after eating? ☐ Yes ☐ No ☐ Diarrhea ☐ Vomiting ☐ Itching ☐ Difficulty Swallowing

Does your child eat any of the following: ☐ Yes ☐ No
If yes, circle those that apply

Dirt Clay Paint Chips Ice Chips Refrigerator Frost
Cornstarch Laundry Starch School Paste Pencils

Child's Name ______________________________ **Birth Date** ____________________

SPECIAL HEALTH NEEDS / CHRONIC ILLNESS	CIRCLE ONE	
Asthma	**Yes**	**No**
Anemia	**Yes**	**No**
Diabetes	**Yes**	**No**
Seizures	**Yes**	**No**
Pediatric First Aid Needs	**Yes**	**No**
Other Special Health Needs – please explain ______________________________	**Yes**	**No**

BIRTH HISTORY					
Was your child premature?	**Yes**	**No**	While in the hospital, did your child experienced any health complications?	**Yes**	**No**
Was your child exposed to cigarette smoke?	**Yes**	**No**			

EARS AND EYES					
Do you have any concerns about your child's hearing?	**Yes**	**No**	Do you have any concerns about your child's vision?	**Yes**	**No**
Use a hearing device?	**Yes**	**No**	Has your child ever worn glasses?	**Yes**	**No**
If yes, to any of the above, please explain					

FAMILY HISTORY					
Mother's Health Status ☐ Good ☐ Fair ☐ Poor			Father's Health Status ☐ Good ☐ Fair ☐ Poor		
While pregnant did the mother drink alcoholic beverages that affected the development of the child?	**Yes**	**No**	While pregnant did the mother take any drugs that affected the development of the child?	**Yes**	**No**
If yes, to any of the above, please explain:					
Is your child exposed to second hand smoke?	**Yes**	**No**			

SOCIAL – EMOTIONAL DEVELOPMENT					
Does child have			**Does child have**		
Problems getting along with other children the same age?	**Yes**	**No**	Aggressive behavior?	**Yes**	**No**
Problems getting along with other family members?	**Yes**	**No**	Extreme shyness?	**Yes**	**No**
Problems sleeping?	**Yes**	**No**	Problems separating from parent/guardian?	**Yes**	**No**
Temper tantrums?	**Yes**	**No**	Other concerns you may have about your child's behavior		
Severe fears?	**Yes**	**No**			
Currently receiving mental health services?	**Yes**	**No**	**If yes**, agency name		

DISABILITIES		
Does your child have an Individualized Education Plan (IEP) with your local school district of residence or County Office of Education program? If yes, please attach copy of the most recent IEP.	**Yes**	**No**
Does your child have an Individual Family Service Plan (IFSP) with an early intervention program, regional center, County Office of Education, or school district? If yes, please attach copy of the most recent IFSP.	**Yes**	**No**
Additional information about your child's disability or other developmental concerns. Please explain if yes circled above		

PARENT AUTHORIZATION FOR PROGRAM SERVICES

I understand that Head Start is a comprehensive program that will provide many services to support my child and family. Classroom observations and screenings are part of the program, which enable staff and SCCOE contracted consultants to plan for my child's individual development. I understand that the program will keep me informed as each service is completed and will provide me the results of all procedures and services my child receives.

I give permission for Head Start staff to complete the following with my child: ☐ **Yes** ☐ **No**

- Dental Screening
- Vision & Hearing Screenings
- Blood Pressure
- Height & Weight
- Nutrition Assessment
- Social Emotional Screening / Behavioral Health Consultation
- Developmental Screenings/ Other Services

______________________ ____________ ______________________ ____________
Parent/Guardian's Signature **Date** **Family Advocate's Signature** **Date**

Reviewed with parent/guardian of returning children **Date** ____________

Santa Clara County Office of Education

Early Learning Services Department – Head Start Program
408.453.6900

UPDATE ANNUALLY

Authorization to Release Records and Exchange Information
COMPLETE AND RETURN THIS FORM

Child's Name ____ **Birth Date** __________________

Parent/Guardian's Name ____

I hereby authorize the release of records and exchange of information to Santa Clara County Office of Education, Early Learning Services Department Head Start Program.

Employee Name ____

Physical examination, immunizations records (including a Tuberculosis Skin Test), Dental, examination and treatment plan, all assessment or diagnostic reports related to my child's health and development, and Individualized Education Program (IEP) and/or Individualized Family Service Plan (IFSP) from school districts, regional centers, or other agencies (list below).

Health Care Provider

____

Dental Provider

____

Other

____

All release of information about my child will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Private Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2004; and Head Start Performance Standards (1301, 1304, 1305, and 1308).

I understand this information is strictly confidential and will be used to provide necessary services and to permit statistical reporting on the results of screenings. This authorization shall be valid for one year from date it is signed.

____ ___________________________

Parent/Guardian's Signature **Date**

Santa Clara County Office of Education

Early Learning Services Department – Head Start Program
408.453.6900

UPDATE ANNUALLY

Authorization to Share Records

COMPLETE AND RETURN THIS FORM

Child's Name ____ **Birth Date** ________________________

Parent/Guardian's Name ____

The Santa Clara County Office of Education Head Start / Early Head Start Program has established partnerships with other child care agencies to be able to provide quality child care and family services to a larger number of children and families. If you allow us to share your enrollment application and pertinent information with our child care partners it could help us to find an opening for your child sooner. Children and families served by our child care partners receive all of the same benefits of a high quality Head Start or Early Head Start experience as is available in our directly operated classrooms.

If you consent to this release you may be contacted by one of our child care partner agencies about enrollment opportunities in their program.

Child Care Partners of the SCCOE Head Start / Early Head Start Program:

- East Side Union High School District Child Development Program (Early Head Start)
- Kidango, Inc.
- Mountain View Whisman School District
- SJB CDC
- State Preschool Programs
- San Jose Unified School District Young Families Program (Early Head Start)
- Community Child Care Council of Santa Clara County, Inc. (4C's - Early Head Start)

All release of information will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Privacy Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2004; and Head Start Performance Standards (1301, 1304, 1305, and 1308).

☐ Yes, I authorize the release of my child's enrollment application and pertinent information to be sent to child care partner agencies to facilitate the enrollment of my child into a preschool program.

☐ No, I do not authorize the release of my child's enrollment application and pertinent information to be sent to child care partner agencies.

____ ______________________________

Parent/Guardian's Signature **Date**

Santa Clara County Office of Education

Early Learning Services Department – Head Start Program

(408) 453-6900

Dental Examination

Child's Name ________________________________ **Birth Date** ________________________

Center Name ________________________________ **Entry Date** ________________________

AUTHORIZATION FOR RELEASE OF INFORMATION / AUTORIZACIÓN PARA REVELAR INFORMACIÓN / LỜI CHO PHÉP QUẢNG BÁ CHI TIẾT

I authorize release of dental information contained in this report to the Head Start Program

Yo autorizo que la información dental que aparece en este reporte sea revelada al Programa Head Start

Tôi cho phép quảng bá các chi tiết y khoa ở trên bản báo cáo này đến Chương trình Head Start.

____ ________________________

Parent/Guardian's Signature / Firma Del Padre-Tutor / Phụ huynh hoặc Giám hộ ký tên **Date / Fecha / Ngày**

Dear Dental Provider:

Please fill out this form completely, sign, and return to the child's parent/guardian listed above. If the child requires more than a routine check-up, we will require information when the initial examination is done and when treatment has been completed*. ***Please note: when routine care is provided by a hygienist, Head Start guidelines require a dentist signature to ensure that care has been provided.***

Date of most recent dental examination ________________________

☑ **Results**

- ☐ Child received prophylaxis, OHI and fluoride application
- ☐ Child had x-rays taken
- ☐ Was child prescribed fluoride ☐ Yes ☐ No
- ☐ Decay ☐ Yes ☐ No
- ☐ Is treatment required at this time other than preventive care? ☐ Yes ☐ No
- ☐ Class I Prevention (sealant/fluoride/prophylaxis)
- ☐ Class II Moderate dental problems (cavities into dentin – less than 3 teeth)
- ☐ Class III Severe dental problems (more than 3 teeth have cavities, cavities involving the pulp)
- ☐ Class IV Emergency dental treatment required (abscess/pain/rampant decay)
- ☐ Next appointment date for routine care ________________________

Dentist's office stamp/name, phone number, and address (required) ________________________________

____

Dentist's Signature ________________________________ **Date** ________________________

***COMPLETE THIS SECTION ONLY IF TREATMENT OTHER THAN PREVENTATIVE CARE IS REQUIRED.**

☑ ***Summary of Treatment***

- ☐ Treatment completed ☐ Yes ☐ No Date ________________
- ☐ Pulpal treatment
- ☐ Extraction of non-restorable teeth ☐ Space maintainers
- ☐ Restoration of decayed teeth (fillings /crowns)
- ☐ Referred to specialist (Dentist name & specialty) ________________________________
- ☐ Next appointment date for treatment ________________________
- ☐ Other ____

Dentist's Signature *(treatment required)*** ________________________________

CHDP DENTAL PROVIDERS

Cyrus M. Akhbari **Pediatric Dentistry** 1201 Park Avenue, Suite 2 San Jose, CA 95126 (408) 971-9990 Spanish/Farsi/Vietnamese	**Dental Image** **Adrienne N. Lan Van** 2114 Senter Road, Suite 14 San Jose, CA 95112 (408) 298-8187 Spanish/Vietnamese	**Daisy G. Ison** 2340 McKee Road, Suite 22 San Jose, CA 95116 (408) 272-8855 Spanish/Tagalog
Evergreen Dental Group 3162 Newberry Avenue San Jose, CA 95118 (408) 274-9600 Spanish – Closed Mondays	**Santa Clara County Dental Center** 500 Tully Road San Jose, CA 95111 (408) 808-6102 Spanish	**Jackson Family Dental** 2324 Montpelier, Suite 3 San Jose, CA 95116 (408) 937-5950 Spanish/Farsi
Lucky Dental 2230 Story Road, Suite 20 San Jose, CA 95122 (408) 928-6000 Spanish/Chinese	**San Jose Dental Surgery Center** **Children's Dental Clinic** 1998 Alum Rock Avenue San Jose, CA 95116 (408) 240-9000 Spanish/Vietnamese	**Maria Villar** **Willow Dental Health Center** 283 Willow Street San Jose, CA 95110 (408) 298-6411 Spanish
Son A. Tran 2060 Aborn Road, Suite 150 San Jose, CA 95121 (408) 239-0816 Vietnamese	**Asadi H** 3535 Ross Avenue, Suite 105 San Jose, CA 95124 (408) 267-5600 Spanish/Farsi	**Children's Dental Center** 1153 South King Road San Jose, CA 95122 (408) 240-0250 Spanish/Vietnamese
Indian Health Center Dental Department 1333 Meridian Avenue San Jose, CA 95125 (408) 445-3400 ext. 230 or 280 Spanish Saturdays by appointment only	**Tino Cuong Tonthat, DDS** 56 North 13th Street #102 San Jose, CA 95112 (408) 295-2530 Spanish/Vietnamese Monday – Friday Saturday by appointment only	**Devinder S. Shoker** 1295 South Park Victoria Drive Milpitas, CA 95035 (408) 945-0411 Spanish/Vietnamese/Hindi/Tagalog
Children's Dental Center 897 West El Camino Real Sunnyvale, CA 94087 (877) 567-6453 (408) 701-5882	**City Dental Center** 7671 Monterey Road, Suite C Gilroy, CA 95020 (408) 842-5000 Spanish/Farsi	**South Valley Dental Clinic** 7475 Camino Arroyo Circle Gilroy, CA 95020 (888) 334-1000 Spanish
South County Dental Center **Gardner Health** 7526 Monterey Street Gilroy, CA 95020 (408) 848-9436 Spanish Open Monday through Saturday	**San Benito Health Foundation** **Dental Department** 351 Felibe Drive Hollister, CA 95023 (831) 637-5306	**Virginia Cavero, DSS** 345 5th Street, Suite 2 Hollister, CA 95023 (831) 636-6510
Santa Ana Dental 4 East Street Hollister, CA 95023-4004 (831) 634-0411	**Terry Slaughter, DDS** 901 Sunset Drive, Suite 5 Hollister, CA 95023 (831) 636-8484	

Your child could be eligible for free dental exam.

Call the numbers below for information on free or low cost children's health insurance programs:

Children's Health Initiative	**1 (888) 244-5222**
Child Health & Disability Prevention Program	**1 (800) 689-6669**
Medi-Cal Eligibility	**1 (800) 541-5555**
Santa Clara Family Health Foundation	**1 (877) 680-4555**

Santa Clara County Office of Education

Early Learning Services Department – Head Start Program

CHILD HEALTH ASSESSMENT REPORT – CONFIDENTIAL

Health Care Professional: Please complete this form and return to parent/guardian on the day of visit.

Child's Last Name	First name	Initial	Sex	Birth Date		
				MONTH	DAY	YEAR
			M F			

SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

AUTHORIZATION FOR RELEASE OF INFORMATION / AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN / LỜI CHO PHÉP QUẢNG QUÁ CHI TIẾT

I authorize release of medical information contained in this report to the Head Start Program / Yo autorizo que la información médica que aparece en este informe sea compartido con el Programa Head Start / Tôi đồng ý chia sẻ các chi tiết y khoa trong bản báo cáo này với Chương trình Head Start

SIGNATURE OF PARENT OR GUARDIAN / FIRMA DEL PADRE O TUTOR / PHỤ HUYNH HOẠC GIAM HỌ KY TÊN	DATE / FECHA / NGAY

HEALTH CARE PROVIDER MUST COMPLETE ALL ITEMS BELOW

Date of Service Month Day Year	*Child's Age Years Months*	*Allergies*

Height / Length Required (Inches)	*Weight Required (Pounds)*	*BMI Percentile ______________ (2, 3, 4, 5 yrs. old only) *Over weight? ☐ Yes ☐ No If yes, method of treatment ________________________*	*0 – 24 Months Head Circumference (Centimeters) __________________*	*Blood Pressure (3,4,5 yrs old) Earlier if at risk as determined by health care provider / BP Elevated _________________*	*Vision Chart Exam OD ______________ OS ______________ OU ______________ Corrected/Uncorrected*

Please indicate outcome for each screening procedure (Refer to Periodicity Schedule on reverse of form)	✓ No Problem Suspected	✓ Problem Suspected
Developmental Screening 9, 18, and 30 months		
Autism Screening 18 and 24 months		
Developmental Surveillance 1-6, and 12,15, 24 mos., and 3-5 yrs old		
Psychosocial / Behavioral Assessment		
History and Physical Exam		
Dyslipidemia Screening 24 months and 4 yrs old		
Oral Health 6 months - 5 yrs old *Was child prescribed fluoride* ☐ *Yes* ☐ *No* *Was Child Referred to a Dentists* ☐ *Yes* ☐ *No*		
Fluoride Varnish 6 mos - 5 yrs old as determined by health care provider ☐ *Yes* ☐ *No*		
Anticipatory Guidance		
New Born Blood Screening 1-2 months as determined by health care provider		

** If a problem is suspected or diagnosed at this visit, please note treatment plan and special care instructions or restrictions in this area.*

Hemoglobin/Hematocrit: to be performed at 12 mos and when indicated by risk assessment starting at 4 mos; and older as determined by health care provider ☐ Risk Assessment (Please check box)	*Hgb Values* Date ________ ☐ *N/A*	*Hct Values* Date _________ ☐ *N/A*	**Anemia Diagnosis* ☐ *Yes* ☐ *No* ☐ *N/A* *If yes, method of treatment* ______________________	*Has child been diagnosed with food Allergies?* ☐ *Yes* ☐ *No* ☐ *N/A* *If yes, please explain* ______________________

Blood Lead Level (BLL)-CA Law mandates: to be performed at 12 and 24 months; Test at 24-72 months, if not previously tested	*BLL Value* Date	** Need status of BLL Value*
Blood Lead Risk Assessment *Required at 6 to 18 months; then, annually at 2, 3, 4, 5 yrs.*	☐ **Blood Lead Risk Assessment** (Please check box)	

If tests were not done, please explain why?

☐ **0 - 36 months old – Sensory Screening Hearing Clinical Assessment** Concern ☐ Yes ☐ No

☐ **0 - 35 months old – Sensory Screening Vision Clinical Observation** Concern ☐ Yes ☐ No

☐ **4 - 5 yrs. old – Hearing Screening** ☐ **Pass** ☐ **Failed** ☐ **Re-Screen** **Concern** ☐ **Yes** ☐ **No**

☐ **3 - 5 yrs. old – Vision Screening** ☐ **Pass** ☐ **Failed** ☐ **Re-Screen** **Concern** ☐ **Yes** ☐ **No**

Tuberculin Verbal Risk Assessment to be performed at <1, 6, 12, and 24 mo.; then, annually at 3, 4, and 5 yrs old	☐ *Verbal Risk Assessment Completed (Please check box)*

** Is TB Test required at this time?* ☐ Yes ☐ No	** Complete this section only if TB Test is required*	Date Given	Date Read

Results in millimeters ____________ ☐ *Negative* ☐ *Positive* *Date X-Rays Taken* ______________________ *X-Rays Results* ________________________

Child needs Immunizations? ☐ Yes ☐ No *Immunizations given today* *Date* __________________

Polio ____ *DTP* ____ *MMR* ____ *HIB* ____ *Hepatitis B* ____ *Varicella* ____ *PCV* ____ *Other* ______________________________________

Health Care Professional (Include name, address, and telephone number)	*Referred to*	*Telephone Number*

Provider's Signature	*Child is up-to-date on a schedule of age appropriate preventive and primary health care* ☐ Yes ☐ No If no, please explain ______________________________________	*Date*

HEAD START / EARLY HEAD START PERIODICITY SCREENING GUIDELINES

BRIGHT FUTURES / AMERICAN ACDEMY OF PEDIATRICS
RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC HEALTH CARE

Note: These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures.

	INTERVAL TO NEXT HEALTH ASSESSMENT												
AGE[1]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 yrs**	**4 yrs**	**5 yrs**
HISTORY													
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS													
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●				
Weight for Length	●	●	●	●	●	●	●	●					
Body Mass Index[5]									●	●	●	●	●
Blood Pressure[6]	★	★	★	★	★	★	★	★	★	★	●	●	●
SENSORY SCREENING													
Vision[7]	★	★	★	★	★	★	★	★	★	★	●	●	●
Hearing	★	★	★	★	★	★	★	★	★	★	★	●	●
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT													
Developmental Screening[9]					●			●		●			
Autism Screening[10]								●	●				
Developmental Surveillance	●	●	●	●		●	●		●		●	●	●
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment[11]													
Depression Screening[12]													
PHYSICAL EXAMINATION[13]	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]													
Newborn Blood Screening[15]	● ⟶	⟶											
Critical Congenital Heart Defect Screening[16]													
Immunization[17]	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[18]			★			●	★	★	★	★	★	★	★
Lead Screening[19]				★	★	● or ★[20]		★	● or ★[20]		★	★	★
Tuberculosis Testing[21]	★			★		★			★		★	★	★
Dyslipidemia Screening[22]									★			★	
STI/HIV Screening[23]													
Cervical Dysplasia Screening[24]													
ORAL HEALTH[25]				★	★	● or ★		● or ★	● or ★	● or ★	●		
Fluoride Varnish[26]				⟵	⟵	⟵	⟵	●	⟶	⟶	⟶	⟶	⟶
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●

KEY	● To be performed	★ Risk assessment to be performed with appropriate action to follow, if positive	⟵ ● ⟶ Range during which a service may be provided

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.
Please refer to AAP Bright Futures Schedule for health assessment by age group.

Pediatric Primary Care Providers

Valley Health Center Bascom
750 South Bascom Avenue
San Jose, CA 95128
1 (888) 334-1000

Valley Health Center Tully
500 Tully Road
San Jose, CA 95111
1 (888) 334-1000

Valley Health Center East Valley
1993 McKee Road
San Jose, CA 95116
1 (888) 334-1000

Valley Health Center Fair Oaks
660 South Fair Oaks Avenue
Sunnyvale, CA 94086
1 (888) 334-1000

Franklin-McKinley Neighborhood Clinic
645 Wool Creek Drive
San Jose, CA 95112
1 (408) 283-6051

San Jose High Neighborhood Clinic
1149 East Julian Street, Building H
San Jose, CA 95116
1 (408) 535-6001

Indian Health Center
1333 Meridian Avenue
San Jose, CA 95125
1 408) 445-3400

San Jose Foothill Family Community Clinic
2880 Story Road
San Jose, CA 95127
1 (408) 729-4282

Washington Neighborhood Health Clinic
100 Oak Street
San Jose, CA 95110
1 (408) 295-0980

Gardner Health Center
195 East Virginia Street
San Jose, CA 95112
1 (408) 918-5500

St. James Health Center
55 East Julian Street
San Jose, CA 95112
1 (408) 918-2600

Planned Parenthood, Blossom Hill
5440 Thornwood Drive, Suite G
San Jose, CA 95123
1 (408) 281-9777

Planned Parenthood, San Jose
1691 The Alameda
San Jose, CA 95126
1 (408) 287-7526

Planned Parenthood, Mar Monte
2470 Alvin Avenue, Suite 60
San Jose, CA 95121
1 (408) 274-7100

Mayview Community Health Center at Mountain View
900 Miramonte Avenue
Mt. View, CA 94040
1 (650) 965-3323

Planned Parenthood, Mt. View
225 San Antonio Road
Mt. View, CA 94040
1 (650) 948-0807

Gardner South County Health Center
7526 Monterey Road
Gilroy, CA 95020
1 (408) 848-9400

Gilroy Neighborhood Health Clinic
7861 Murray Avenue
Gilroy, CA 95020
1 (408) 842-1017

Valley Health Center Gilroy
7475 Camino Arroyo Circle
Gilroy, CA 95020
1 (888) 334-1000

Hazel Hawkins Community Health Clinic
930 Sunset Drive, Building 3
Hollister, CA 95023
1 (831) 636-2664

Office hours
Mon - Fri – 8:00 am – 8:00 pm
Saturday - 8:15 am – 5:00 pm
Sunday – 8:15 am – 12:00 noon

San Benito Health Foundation
351 Felice Drive
Hollister, CA 95023
1 (831) 637-5306

Your child could be eligible for free dental exam.

Call the numbers below for information on free or low cost children's health insurance programs:

Children's Health Initiative	**1 (888) 244-5222**
Child Health & Disability Prevention Program	**1 (800) 689-6669**
Medi-Cal Eligibility	**1 (800) 541-5555**
Santa Clara Family Health Foundation	**1 (877) 680-4555**