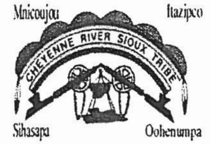


Cheyenne River Head Start Program

Application for SY 2022-2023

To be **COMPLETE**, the following must be submitted:

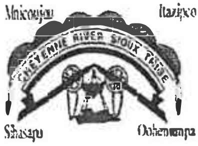
- **Birth Certificate:** If child was born in South Dakota see Family Services to obtain a free one
- **Income Documentation**
- **Physical Examination:** This **MUST** be turned in before your child can begin school.
- **Lead Testing & Hematocrit/Hemoglobin is Required:**
- **Updated Immunization:** Please check with your medical provider on your child's immunization
- **Degree of Indian Blood:** If child is not enrolled, please submit parent's DIB:
  - CRST Enrollment Office 964-6612
- **Food Stamp Documentation**
- **Custody Papers (if applicable)**
- **Medicaid/CHIP Numbers:** Please write number on application
- **IEP** (Individual Education Plan) **or IFSP** (Individual Family Service Plan)
- **If your child has a food and/or milk allergy or a special diet prescription please have your medical provider complete the form and it MUST BE signed by a Medical Doctor (MD).**

ALL documents MUST be submitted to the Family Services before the 1st day of School.

(This includes Birth Certificate, Income Documentation, Physical Examination, Immunization, Hematocrit/Hemoglobin, Lead results, Medicaid number and Degree of Indian Blood)

Call 964-8710 for information:
Michelle West, ERSEA Manager

If you DO NOT want your child to be taken for vision or hearing screenings by Head Start, it will be your responsibility to submit results of these screenings within 45 days of the child's first day of school.



Cheyenne River Head Start Program
CHILD APPLICATION
P. O. Box 590, Eagle Butte, SD 57625
Phone: 605-964-8713 Fax: 605-964-8705

Office Use Only:
Date Received__________
Center: ______________

TEACHER REQUEST (EB ONLY): ____________________

Please COMPLETE all areas of this application. **Chronological Age:**__________

Applicant Information: First Name: MI Last Name:	**Date of Birth:**	**Gender:** Male: ______ Female: ______

Living Address:	**Mailing Address of Primary Adult (physical custody)**
Street/House No.: ____________________	Street/P.O. Box: ____________________
Town/City: ____________________	Town/City: ____________________

Child lives with: (Check all that applies)

☐ Mother ☐ Father ☐ Step-Father ☐ Step-Mother ☐ Foster Parent(s) ☐ Legal Guardians
☐ Grandparent(s) ☐ Other Relative Other (specify): ____________________

Ethnicity of Child:

☐ American Indian/Alaska Native ☐ Asian ☐ African American or Black
☐ Biracial/Multi-Racial ☐ Native Hawaiian or Pacific Islander ☐ White

Household Composition/Ethnicity: AI/AN: American Indian/Alaska Native **Asian** **AA:** African American or Black
MR/BR: Multiracial or Biracial **NH/PI**: Native Hawaiian or Pacific Islander **W**: White

First Name: Last Name:	Date of Birth	Relationship to Child:	Ethnicity:

Child and/or Family Information:

Is family on SNAP: Yes: ____ No ____ Is child on WIC: Yes: ____ No ____ Is family on SSI? Yes: ___ No: ____
Is family on TANF Yes: ____ No: ____ Formerly on TANF: Yes: ____ No: ____
Is family homeless: Yes:____ No: ____ Is child toilet trained: Yes: ____ No: ____
Does child have food and/or milk allergy: Yes: ____ No: ____ (Form signed by Dr. must be submitted)
Is child on IEP (Individual Education Plan)? Yes: ____ No: ____
Primary language of child: ____________________ 2nd Language of child: ____________________

Medical Information for Child:

Is child currently on: ☐ Medicaid Only ☐ CHIP Only ☐ Combined Medicaid/CHIP ☐ Private Insurance
☐ Military Insurance ☐ No Insurance

Medicaid/CHIP number: ____________________

Do you utilize Indian Health Service: ☐ Yes ☐ No

Medical Home (name of hospital/clinic): ____________________
Address:____________________ Phone Number: ____________

Does child have access to regular dental care: ☐ Yes ☐ No

Dental Home (name of dentist/dental clinic):____________________
Address: ____________________ Phone Number: ____________

Primary Adult:

First Name: MI Last Name

Date of Birth: Relationship to Child:

Telephone Number Information:

Home: ______________ Work: ______________

Cell: ______________ Message: ___________

Secondary Adult:

First Name: MI Last Name:

Date of Birth: Relationship to Child:

Telephone Number Information:

Home: _______________ Work: ____________________

Cell : ________________ Message: ___________________

Primary Adult Employment & Education

Employment:

☐ Full Time ☐ Part-Time ☐ Seasonal ☐ Unemployed

Employer name:___________________________

Are you attending school/job training? ☐ Yes ☐ No

If Yes, where: _______________________________

Are you active in any branch of the United States Military?

☐ Yes ☐ No

Are you a **Veteran** of the United States Military?

☐ Yes ☐ No

Highest level of education completed:

☐ 9th or less ☐ 10th ☐ 11th ☐ 12th (didn't finish)

☐ High School graduate ☐ GED ☐ Some college

☐ Associate's Degree ☐ BS/BA ☐ MA/MS

☐ Vocational ☐ Doctorate ☐ Other: ___________

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian

☐ African American or Black ☐ Bi-Racial/Multi-Racial

☐ Native Hawaiian or Pacific Islander ☐ White

Secondary Adult Employment & Education

Employment:

☐ Full-Time ☐ Part-Time ☐ Seasonal ☐ Unemployed

Employer Name: ______________________________

Are you attending school/job training? ☐ Yes ☐ No

If Yes, where: _________________________________

Are you active in any branch of the United States Military?

☐ Yes ☐ No

Are you a **Veteran** of the United States Military?

☐ Yes ☐ No

Highest level of education completed:

☐ 9th or less ☐ 10th ☐ 11th ☐ 12th (didn't finish)

☐ High School graduate ☐ GED ☐ Some college

☐ Associate's Degree ☐ BS/BA ☐ MA/MS

☐ Vocational ☐ Doctorate ☐ Other: ___________

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian

☐ African American or Black ☐ Bi-Racial/Multi-Racial

☐ Native Hawaiian or Pacific Islander ☐ White

Transportation/Emergency Contact:

Pick-Up: Will bring in: _________

House Number: __________

Street/Housing Area: __________________________

Drop-Off: Will pick up: __________

House Number: __________

Street/Housing Area: ______________________

Emergency contact: Please **DO NOT** list yourself; this person will be contacted when the parent/guardian cannot be reached:

Name of Person: ____ Relationship to Child: _______________

House Number: __________ Street/Housing Area: ____

Phone Numbers: Home: _______________ Work: ______________ Cell: ________________

Release: Please list the people who you authorize to pick up your child from the center/classroom:

____

____

Volunteer:			
Mother:	Father:	Guardian	Activity:
			Read stories to children in classroom
			Help in kitchen (cooking, washing dishes, etc.)
			Assist teaching staff with prep time
			Assist with Week of the Young Child activities

__________ **NO,** I cannot volunteer at this time.

Parent Consent:

While my child is participating in the CRST Head Start Program, I agree to the following:

_____ Yes _____ No 1. That my child may be transported, as necessary, to services to and from the center for educational field trips, neighborhood walks or in an emergency, provided that the driver has liability insurance and a valid driver's license.

_____ Yes _____ No 2. That, in case of an emergency and if the parent/guardian cannot be contacted, qualified Head Start personnel may provide first aid or obtain emergency medical care, if needed.

_____ Yes _____ No 3. That my child may receive all necessary health (vision, dental, hearing) and developmental (DIAL-4) screenings, assessments and laboratory (lead tests required by the program, and if possible, I will accompany my child for these exams. I understand that I will receive results of the screenings and information on any follow-up. These may be performed by Head Start or non-Head Start staff.

_____ Yes _____ No 4. I understand that Mental Health professional will be making routine mental health observations at Cheyenne River Head Start centers. I hereby give my permission for the mental health professionals to review my child's records and to advise on behavior issues.

_____ Yes _____ No 5. That this is my authorization for my child's Developmental Screenings, Assessment and Summary of Services will be transferred to the parent/school, if requested by either parent or school.

All children's records are kept in strict confidence and reviewed only by Head Start or Pre-school staff, Health and Mental Health service providers and Multidisciplinary Team members, unless otherwise instructed, in writing, by the parents/guardians. Statistical data will be used for annual Program Information Reports.
I have read and understand the above statements; I give my consent for those services marked "Yes".

I certify that the information provided on this application is correct and to the best of my knowledge. I also understand that all information will be confidential within the program. All information can be verified for accuracy. If any information changes during the school year, I understand that it will be my responsibility to inform the staff.

Parent/Guardian Signature: ______________________________________ Date: ____________

CRST HEAD START RELEASE OF INFORMATION FORM

Purpose: To provide direct services to families in meeting basic family needs/concerns.

_____ ***YES*** **I give the CRST Head Start Program permission to release/obtain information with the understanding that the information will be used to assist my family in receiving services. I also understand that I will be an active partner in the process.**

_____ ***NO*** **I do not give permission for the CRST Head Start Program to assist my family in obtaining any services. My family's needs are being met at this time or I am able to obtain services on my own.**

Disabilities & Education:

Preschools (Dupree, Isabel, Timber Lake, Sunny Days, Other: ____________________)
Child Developmental Clinic (Services to infants and young children with special needs, referrals & screenings)
Title I (Jump Start Program)

Family Services:

BIA Social Services (includes GA)
Child Support Enforcement (SD Office of Child Support Enforcement, CRST Child Support Enforcement)
Domestic Violence (Sacred Heart Center & Family Violence Prevention)
Employment (CRST Personnel, Employment & Training, BIA Personnel, TERO, etc.)
Energy Assistance (LIHEAP, Weatherization/HIP, Moreau-Grand, The Main, etc.)
Four Bands Healing Center (Substance Abuse, Al-Anon, Ala-Teen, Co-Dependency, etc.)
Housing (CRST Housing Authority, Habitat for Humanity, Oti Kaga, Inc., Wheatridge/Prairie/Evergreen)
Legal Services (Dakota Plains, Public Defenders, Children's Court, Civil/Criminal)
Nutrition Services (Food Pantry, WIC, Food Distribution, etc.)
Sacred Heart Center (Domestic/Family Violence, clothing assistance, counseling, etc.)
Support Services (Emergency Assistance)
The Main (Heating Assistance, Direct Services-clothing, diapers, etc., After School Activities)

Health & Mental Health:

Counseling Services (Professional Consultation Services, CRST Counseling, Three Rivers, etc.)
Dental Program (dental work, etc.)
Diabetes (, Youth Diabetes Prevention, Diabetes Program)
Eagle Butte Family Horizon Health Center (Physicals/Immunizations)
Faith Clinic (physicals, immunizations)
Indian Health Service (Pediatrics, Field Health, Medical Records – Physicals and Immunizations)
Isabel Clinic (Physicals/Immunizations)
Optometry (Appointments for vision, glasses, contacts, exam results.)
West Dakota Health Center (Physicals/Immunizations)
State Department of Health (Immunizations)

Transition:

____ **I DO** ____ **I DO NOT** give permission for the CRST Head Start program to transfer my child's records to: (name of school): ____________________ where my child will be attending Kindergarten for the SY 2020-2021

Publicity:

___ **I DO** ___ **I DO NOT** give my consent for the Head Start Program to use my child's photograph in the Head Start newsletter and the local media (*West River Eagle, Faith Independent and Timber Lake Topic);* and not on the internet.

If you have more than one child in Head Start, please list both children:

Child:____ **DOB:** ______________
Child:____ **DOB:** ______________

I understand that this form will be valid for one year from the date of my signature.

X__________________________________ **X**____________________
Signature of Parent/Guardian Date

CHILD HEALTH RECORD *HEALTH HISTORY*

Child's Name: ____________________

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS:
Did mother have any health problems during this pregnancy or during delivery?			
Was child born 3 weeks early or late?			
What was child's birth weight?			_____lbs. _____oz.
Did child have any problems at birth?			

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS:
Has child ever been hospitalized or operated on?			
Has child ever had a serious illness?			
Has child ever had a serious accident? (broken bones, head injuries, falls, burns, poisoning?)			

HEALTH PROBLEMS	YES	NO	EXPLAIN "YES" ANSWERS:
Does child have frequent: __ sore throat __ cough __ diarrhea __ trouble urinating __ stomach pain __ vomiting __ Other: ____________			
Has child ever had a convulsion or seizure?			
Is child taking medicine for seizures?			What medicine?________
Is child taking any other medicine now? (Special consent form must be signed for Head Start staff to administer any medication.) Will medicine need to be given to child at Head Start?			What medicine?________ How often?________
Has child had: __ Measles __ Chicken Pox __ Mumps __ Whooping Cough ___ RSV __ Shigella			
Does child have: __ Asthma __ Diabetes __ Epilepsy __ Heart problems __ Frequent ear infections __ Other ____________			
Does child have any allergy problems (rash, itching, swelling, difficulty in breathing) a. When eating foods?			What foods?
b. When taking medication?			What medicine?
c. When near animals, fur, insects, etc.?			How does child react?
__Does child use an Epi Pen?			
Does child squint or rub his/her eyes?			

Child's Name: ____

DISABILITIES	YES	NO	EXPLAIN "YES" ANSWERS:
Does your child have a diagnosed disability?			
Are services being provided:			By whom?____________________
Is child on an IEP or IFSP? (IEP: Individual Education Plan) (ISFP: Individual Family Service Plan			IEP____ IFSP____

If you have a concern with your child's development, you can contact the Developmental Clinic at 964-3900

PHYSICAL/PSYCHOLOGICAL/SOCIAL	YES	NO	EXPLAIN "YES" ANSWERS:
Does child take a daily nap?			How long?
Does child need assistance going to the bathroom?			
Does child have any fears?			
Does child have temper tantrums?			What do you do?
Does your child interact with other children?			Please describe:
Do you discipline your child at home?			What do you do?
Have there been any changes in your child's life in the last six months?			
Is family having any problems that may affect the child?			
Is there anything you want us to know about your child?			

How do you comfort your child?

SPEECH/LANGUAGE	YES	NO	EXPLAIN "YES" ANSWERS:
Do you have difficulty understanding your child?			
Does your child have any difficulty saying what he/she wants?			

FAMILY HEALTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS:
Do the parents/guardians have a disability?			

CRST Head Start Program

Nutrition Form

Child's Name: ______________________________ DOB: ______________

Gender: _____ Female _____ Male

Dietary Habits:

1. What foods does your child especially like? ______________________________
2. Are there any foods your child dislikes? ______________________________

	Yes	No
3. Does your child take vitamins and mineral supplements? If "Yes", they would have to be taken at home.	_____	_____
(a) Were they prescribed?	_____	_____
4. Is there any food your child should not eat for medical, religious or personal reasons? ______________________	*_____	_____
5. Is your child on a special diet?	*_____	_____

If "Yes", the doctor MUST fill out & sign the medical diet prescription form and special diet request forms that are in the enrollment packet.

6. Has there been a big change in your child's appetite in the last month	*_____	_____
7. Does your child take a bottle?	*_____	_____
8. Does your child eat or chew things that aren't food?	*_____	_____
9. Does your child have trouble chewing or swallowing?	*_____	_____
10. Does your child often have: (a) Diarrhea?	*_____	_____
(b) Constipation?	*_____	_____
11. Do you have any concerns about what your child eats? If so, you are welcome to visit your child's classroom.	*_____	_____

* Starred answers may require follow-up. Please explain details or give additional comments here:

____

____

12. About how often does your child eat a food from each of the following groups?

Approximate number of times a week (circle the numbers for each answer.)

Recommendations from the Food Pyramid:

1. **Meat Group** (Includes milk, meat) (2 servings daily)	0*	*1	2	3	4	5	6	7	7+
2. **Vegetable Group** (3 servings daily)	0*	*1	2	3	4	5	6	7	7+
3. **Fruit Group** (Includes juice – 2 servings daily)	0*	*1	2	3	4	5	6	7	7+
4. **Grain Group** (1 serving daily)	0*	*1	2	3					

* Starred answers may require follow-up. Please explain details or give additional comments here:

____

____

CHILD DENTAL FORM

Is child on Medicaid/CHIP? Yes [ ] No [ ] Please list number: ____________________

Child's Name: ________________________________ Health Record No. ____________

Date of Birth: ____________________ Community where you live: ____________________

Phone No. (Home) ______________ Work: ______________ Cell: ________________

Mailing Address: ____

____

PLEASE CHECK:	**YES**	**NO**
1. Does child have a toothache now?	[ ]	[ ]
2. Has child received medical care in the last 2 years?	[ ]	[ ]
3. Have child ever been hospitalized?	[ ]	[ ]
4. Has child taken medication in the the last 2 months?	[ ]	[ ]
5. Is child allergic to or made sick by any medication such as penicillin, aspirin or codeine?	[ ]	[ ]
6. Has child ever had a bleeding problem that needed medical treatment?	[ ]	[ ]
7. Does child have chest pains?	[ ]	[ ]
8. Do you have reason to believe that the child has been exposed to AIDS or HIV?	[ ]	[ ]
9. Does child or anyone in the family have diabetes?	[ ]	[ ]

Has child ever had any of the following?	**Yes**	**No**
10. Hepatitis	[ ]	[ ]
11. Heart murmur	[ ]	[ ]
12. Heart attack	[ ]	[ ]
13. High blood pressure	[ ]	[ ]
14. Rheumatic fever	[ ]	[ ]
15. Heart valve or pacemaker	[ ]	[ ]
16. Artificial joint	[ ]	[ ]
17. Anemia	[ ]	[ ]
18. Ulcers	[ ]	[ ]
19. TB or lung disease	[ ]	[ ]
20. Asthma	[ ]	[ ]
21. Sinus trouble	[ ]	[ ]
22. Cancer or tumors	[ ]	[ ]
23. Epilepsy or seizures	[ ]	[ ]
24. Arthritis/rheumatism	[ ]	[ ]
25. Blood transfusions	[ ]	[ ]
26. Kidney problems	[ ]	[ ]
27. Liver problems	[ ]	[ ]
28. Nervous or mental disorders	[ ]	[ ]

Does child have any disease, condition or problem not listed? Yes [ ] No [ ]
(If Yes, please list): ____

Do you have any concerns about child receiving dental services? Yes [ ] No [ ]
(If Yes, please list): ____

IMPORTANT

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns and local anesthesia by signing below. I give authorization for the Head Start staff to take my child to the tribal dental office for such procedures if I am unable to do so.

____ ____________

Signature of Patient or Parental Consent) Date

____ ____________

Signature of Dentist Date

Indian Health Service

OPTOMETRY CLINIC

Eagle Butte, South Dakota 57625

Child Vision History

(Please complete this form for your child; this is taken to the Optometry Office when child is screened)

Child's Name: ______________________________ DOB: __________
Address: ______________________ Home Phone: __________
______________________ Cell #: __________

Insurance/Medicaid/Medicare #: ______________________

Is this child's first eye exam? Yes: _____ No: _____
When was child's last eye exam? ______________________
Has child worn glasses before: Yes: _____ No: _____ Contacts? Yes: ___ No: ___
Does child wear glasses now? Yes: _____ No: _____ Contacts? Yes: ___ No: ___

Has the child had any:			*If Yes, please explain:*
Head injuries	Yes	No	______________
Eye injuries	Yes	No	______________
Eye diseases	Yes	No	______________
Eye surgeries	Yes	No	______________

Is child taking any medications? Yes No
If Yes, please list medications: ______________

Does child have:		
Diabetes	Yes	No
Hypertension	Yes	No
Heart trouble	Yes	No
Thyroid trouble	Yes	No
Asthma	Yes	No
Allergies	Yes	No
Sinus problems	Yes	No
Arthritis	Yes	No
Other: ______________		

Does anyone in the family have:		
Diabetes	Yes	No
Hypertension	Yes	No
Heart trouble	Yes	No
Thyroid trouble	Yes	No
Asthma	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Amblyopia (Lazy Eye)	Yes	No
Eye turns	Yes	No
Other: ______________		

Has child complained about any of the following problems?

Blur at a distance	Yes	No
Double vision	Yes	No
Headaches	Yes	No
Difficulty reading	Yes	No
Itching eyes	Yes	No
Blur at near objects	Yes	No
Eye pain	Yes	No
Eye strain	Yes	No
Flashes of light	Yes	No
Tearing	Yes	No

Does your child sit very close to the television and/or computer? Yes No
Does your child receive optometry services elsewhere? Yes No
If Yes, please provide name of doctor: ______________ and location of services: ______________.

I hereby give my consent/permission to Head Start to transport my child to the IHS Optometry Clinic for a complete eye exam.

______________________ ______________
(Signature of Parent/Guardian) **(Date)**

CHEYENNE RIVER HEAD START
ONE CALL

CHEYENNE RIVER HEAD START PARENTS AND GUARDIANS:

Cheyenne River Head Start has taken the next step of notification for upcoming inclement weather and various school events.
ONE CALL system has been implemented within the Head Start school system; before doing so, the option to participate will be given to the parents and guardians.
This serve will be utilized for the following reasons:

- Early release
- Upcoming Parent/Teacher conference
- Parent Activity Nights
- Weather related closures
- Cancellation of out-of-town buses
- And any other mass notifications that need to be sent to all concerned parties.

On the bottom half of this letter is the option to sign up for this service or decline this notification services.

ONE CALL NOTIFICATION SYSTEM:

________________________________, student in the Cheyenne River Head Start

I,________________________________, parent/guardian choose:

______Option – Out of One Call Notification
______Option – In to One Call Notification
______change phone number:________________________________

Preferred contact method (check all that apply):
_____Cell (phone number): ____________________
_____Text (phone number):____________________
_____ Email(email address):____________________

Student Center:

____Cherry Creek ____Dupree ______Eagle Butte _____Swiftbird ______Timber Lake ____White Horse

Students Teacher (Eagle Butte Center ONLY):

____

Revised: 1/06/20 ac

Cheyenne River Head Start Program

JOHNSON O'MALLEY FORM

(Verification of Indian Blood)

This information is requested to help the CRST Head Start Program obtain funds from Johnson O'Malley. The degree of Indian blood can be obtained from the Tribal Enrollment Office or the BIA Realty Office of the tribe where the child and/or parents are enrolled. **The form and DIB must be turned in with the application.**

NOT APPLICABLE: ____

CHILD'S NAME:________________________________ DOB: __________
Is the child enrolled with a federally recognized tribe? Yes: ____ No: ____ Pending: ___
If Yes, what tribe: ____
Degree of Indian blood: ____________________ Enrollment Number: __________

FATHER'S NAME: ________________________________ DOB: __________
Is father enrolled with a federally recognized tribe? Yes:____ No: ____ Pending: _____
If Yes, what tribe: ____
Degree of Indian blood: ____________________Enrollment Number: __________

MOTHER'S NAME: ________________________________ DOB: __________
Maiden Name: ____
Is mother enrolled with a federally recognized tribe? Yes: ____ No: ____ Pending: _____
If Yes, what tribe: ____
Degree of Indian blood: ____________________ Enrollment Number: __________

Release of Information

I/We hereby give the CRST Head Start Program authorization to release the above information to the school system where my child will be attending Kindergarten. I/We give permission for the use of the information in the annual JOM Count and also give the CRST Head Start Program staff authorization to obtain the Degree of Indian Blood (DIB) if one is not attached to my child's file. ***The authorization to obtain a Degree of Indian blood is for the Cheyenne River Sioux Tribe ONLY; if my child or one or both parents are enrolled with another tribe, I/We understand that it will be my responsibility to obtain the degree of Indian blood and submit with the application.***

X________________________________ X____________________
Signature of Parent/Guardian Date

CHEYENNE RIVER HEAD START PROGRAM
PHYSICAL EXAMINATION FORM
(Parents fill out top part of form)

Child's Name:____ Sex:_____ Date of Birth:___________
Home Address:____Home Ph#:__________ Cell: __________

The following screening tests are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N" for normal, "S" for suspect or "A" for Atypical/Abnormal, respectively.

REQUIRED	DATE	RESULTS	OPTIONAL	DATE	RESULTS
Present Age		Yrs ___ Mos. ___	TB Test		
Height			Urinalysis		
Weight		*BMI is:	Ova & Parasites		
Blood Pressure			Sickle Cell		
*Hematocrit/Hemoglobin					
*Lead					
Hearing		Type of Test:________________ Right:__________ Left:__________ Comments:			
Vision		Type of Test:________________ Right:__________ Left:__________ Comments:			

Physical Examination/Assessment	Normal	Abnormal	Comments:
General Appearance			
Posture/Gait			
Speech			
Head			
Skin			
Eyes			
1. External Aspect			
2. Optic Fundoscopic			
3. Cover Test			
Ears			
1. External & Canals			
2. Tympanic Membranes			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological/Social			
1. Gross Motor			**What immunizations were given, if any?**
2. Fine Motor			
3. Communication Skills			
4. Cognitive			
5. Self Help Skills			**Does child have Mongolian Spots? Yes___ No___**
6. Social Skills			**If Yes, describe where on body:**
Glands (lymphatic/thyroid)			____
Muscular Coordination			

Child up to date on immunizations/EPSDT? Yes / No

General Statement on Child's Physical Status:

Findings, Treatments, and Recommendations:

Physician/Health Professional Signature:____ Date:______________