BEGIN SHEET- HEALTH

Child _____ **DOB** ____/___/_____ **Child Age** _____ **mo./yr.**

FA/HBT # _____ **Staff Name** _____ **Intake Date** ___/___/___

PAYMENT SOURCE:

- ☐ Combination State All Kids/ Medicaid [All Kids Assist income > 138% FPL - no premiums or co-pays]
- ☐ All Kids Premium Levels 1-2 [income > 209% FPL recipients pay premium & co-pays]
- ☐ Private Insurance (Blue Cross Blue Shield, etc.)
- ☐ Other insurance (Military only) (Circle one or list) Tri-Care or Champion _____
- ☐ No insurance

If NO: Refer family to All kids/Medicaid & enter in Child Plus

WIC: (Is child currently enrolled and receives food vouchers)

☐Yes ☐No ☐N/A – child is 5 yrs. old.

If NO: Refer family to Health Dept. & enter in Child Plus

MEDICAL CARE SOURCE:

☐ Source for ongoing accessible medical care:

Clinic name: _____
Physician name: _____
Town: _____

☐ No source for ongoing accessible medical care.

If NO: Refer family to Medical Clinic & enter in Child Plus

DENTAL CARE SOURCE:

☐ Source for ongoing accessible dental care:

Clinic name: _____
Dentist name: _____
Town: _____

☐ No source for ongoing accessible dental care. **(Start a referral form)**

If NO: Refer family to Dental Clinic & enter in Child Plus

All children must be linked to medical & dental source (see workplans for explanation of linkage)

BEGIN SHEET-HEALTH

Child: _____ FA/HBT #:_____

Fill in health needs on file PRIOR to making an intake visit using reports or by calling Health Aide. Obtain releases and/or make appointments for anything not completed or due within the next 2 months. Make appointments with family while on intake visit.

①- PHYSICAL EXAM / WBC on file at C.O. date ___/___/___ ☐ None of file
Due at 1, 2, 4, 6, 9, 12, 15, 18, 24, 30, 36 months then yearly - Date WBC Due _____

1. When was your child's latest physical exam/WBC? _____
   (Obtain Authorization for Release of Protected Health Information if not on file or more recent than what is on file)

Release obtained ☐ Yes ☐ No (if yes, provider name) _____
Date & time of appt. along with provider name. _____

②-IMMUNIZATION RECORD on file at C.O. ☐ Yes ☐ No - Date imm. Due _____

1. Where does/did child receive immunizations at: ☐ Health Department ☐ Doctor

Release obtained ☐ Yes ☐ No (if yes, provider name) _____
Date & time of appt. along with provider name. _____

③-HCT/HMG (Hemoglobin/Hematocrit) on file at C.O. date ___/___/___ ☐ None on file
Due at 9-12 months and yearly as medically indicated ☐ N/A child too young

1. When was your child's latest HCT/HGM? _____
2. Where did child receive HCT/HGM? ☐ Health Department (WIC) ☐ Doctor
   (Obtain Authorization for Release of Protected Health Information if not on file or more recent than what is on file) (If ever on WIC they may have results)

Release obtained ☐ Yes ☐ No (if yes, provider name) _____
Date & time of appt. along with provider name. _____

④-LEAD on file at C.O. date ___/___/___ ☐ None on file ☐ N/A child too young
Due at 12 and 24mo for EHS children, HS children need only one on file.

1. When was your child's latest lead test? _____ ☐ Health Department (WIC) ☐ Doctor
   (Obtain Authorization for Release of Protected Health Information if not on file or more recent than what is on file) (If ever on WIC they may have results)

Release obtained ☐ Yes ☐ No (if yes, provider name) _____
Date & time of appt. along with provider name. _____

⑤-TB on file at C.O date ___/___/____ ☐ None on file ☐ N/A child too young
Due at 12 months - Physician may sign off if not at high risk and medically necessary

1. Has child ever had a TB skin test? ☐ Yes ☐ No

Release obtained ☐ Yes ☐ No (if yes, provider name) _____
Date & time of appt. along with provider name. _____

Child: _____ **FA/HBT #:**_____

HEAD START ONLY (EHS go to bottom of page):

⑥-HEARING on file at C.O. ___/___/___ ☐ None on file
Due at 36 months and then yearly

1. Has child had hearing screening within the last year? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health Information)
2. Is child being followed by an ENT for hearing problems? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health (V&H) Information)

Release obtained ☐ No ☐ Yes (if yes, provider name) _____
Date & time of appt. along with provider name. _____

⑦-VISION on file at C.O. ___/___/___ ☐ None on file
Due at 36 months and then yearly

1. Has child had vision screening within the last year? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health Information)
2. . Does child wear glasses and/or being followed by an ophthalmologist? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health (V&H) Information)

Release obtained ☐ No ☐ Yes (if yes, provider name) _____
Date & time of appt. along with provider name. _____

⑧-DENTAL EXAM on file at C.O. ___/___/___ ☐ None on file
Due at 36 months and then yearly

1. Has child had dental exam within the last year that is not on file? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health Information)

Release obtained ☐ No ☐ Yes (if yes, provider name) _____
Date & time of appt. along with provider name. _____

EHS ONLY:

⑨- HEARING Did child pass hearing test at birth? ☐ Yes ☐ No ☐ Do not know

1. Is child being followed by an ENT for hearing problems? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health (V&H) Information)

Release obtained ☐ No ☐ Yes (if yes, provider name) _____

2. Does parent have concerns about child's hearing that has not been treated? ☐ Yes ☐ No

Explain: _____ **(If yes, refer to primary care physician)**

⑩- VISION

1. Does child wear glasses and/or being followed by an ophthalmologist? ☐ No ☐ Yes (if yes, obtain Authorization for Release of Protected Health (V&H) Information)

Release obtained ☐ No ☐ Yes (if yes, provider name) _____

2. Does parent have concerns about child's eyes that has not been treated? (Crossed/turned in or out, eyes in constant motion, droopy, watery) ☐ Yes ☐ No
   Explain**:** _____ **(If yes, refer to primary care doctor)**