Northwest Community Action, Inc

PO Box 67 312 North Main Street Badger, MN 56714

Office: (218) 528-3258 Fax: (218) 528-3259 Head Start: (218) 528-3226

www.northwestcap.org

Dear Head Start Parent:

Current Physicals and Dental Exams are required every 12 months for all children enrolled in Head Start. Head Start contracts with the County Nursing Services to complete the physicals. We set up sites in several locations throughout our 4-county service area in the fall, to hopefully make it more convenient for you to complete the physical exam. **If you are unable to keep the appointment, PLEASE call the Head Start Office so other arrangements can be made.** Physicals include: exam, blood pressure, pulse, hemoglobin, lead screening, needed immunizations, vision, hearing, height, weight and nutrition assessment. Any follow-up work needed will be referred to the appropriate professionals. Additional forms will be needed for those referrals.

Your child will also receive a dental assessment by a calibrated dental hygienist at the screening or in the classroom when school starts. This assessment **DOES NOT** take the place of a dental exam done by your family dentist. Enclosed is a Dental Form. Please complete the top half on your child and make an appointment for your Head Start child with a dentist that takes your insurance as soon as possible. Bring the enclosed Dental Form to the appointment.

Physical and dental exams are required within 90 days of enrollment, unless you have been in within the last 12 months. Then you would be due again when that month arrives (example- physical was in April 2021, child will need another physical by the end of April 2022).

Please schedule an appointment with a dentist that takes your insurance, if you need help finding one please contact our office. The Head Start Program could help pay a portion of the balance for the physical and dental exams, fluoride, needed immunizations, lab work and follow-up services, providing you **do not** have any type of insurance that will cover these services. You must contact the office prior to the appointment for authorization if you need assistance paying for the appointment. Families covered by Minnesota state funded insurance, or whose health and/or dental insurance covers these services, must use those funding sources to cover the cost. Head Start cannot cover any remaining costs from Minnesota state funded insurance, but we could help cover a portion of the balance from your private health and dental insurances. This also applies to follow-up services.

If I can be of any assistance, help with a prior authorization or answer any questions you may have, please call our office at 528-3227 or 1-800-568-5319.

Sincerely,
Head Start Health Services

INSURANCE STATUS FORM

NWCA - Head Start/Early Head Start Program
312 North Main Street, PO Box 67
Badger, MN 56714
218-528-3227/800-568-5319

- Child's Name: _____
  (Last) (First) (Middle)

- Parent/Guardian Name: _____
  (Last) (First) (Middle)

- Address: _____
  (Street/Box Number) (City) (State) (Zip)

- Child is covered by:

  _____Health Insurance (Private): _____

  _____ Dental Insurance _____

  _____Medical Assistance _____

  _____ Other _____

  _____ No Insurance

- Is anyone in your household **NOT** covered by Health Insurance? Yes___ No__

- Date: _____

- **REQUIRED sections**

CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-6 YEARS)

Child's Name: _____ ☐ M ☐ F Birthday: _____ Age: _____

Languages spoken at home: _____

Parent/Guardian Name (s): _____

Person Completing form: _____ Date: _____

How often does your child see a doctor or nurse? _____ Date of last dental checkup? _____

Date of your child's most recent comprehensive vision (eye) Exam, if your child received one: _____

The comprehensive vision exam is performed by an optometrist or ophthalmologist.

Does your child have health insurance? ☐ Yes ☐ No ☐ Applied

Please check the boxes if your or your child use, if any:

☐ Early Childhood Family Education	☐ Child & Teen Check-Ups	☐ Child Care Center
☐ Early Childhood Special Education	☐ School-Based-Pre-K	☐ Family/Neighbor Care
☐ Follow Along Program	☐ Private Preschool	☐ Library
☐ Parenting Education	☐ Head Start	☐ WIC
☐ Parks and Recreation Programs	☐ Foster Care	☐ Food Shelf

HEALTH

Please check any concerns that apply to your child and describe:

☐ Allergies: ☐ Food ☐ Medicine ☐ Animals/Insect ☐ Dust/Mold ☐ Seasonal _____

☐ Takes medicines, herbs and/or vitamins: _____

☐ Visits to health specialist(s), hospital stays and/or surgeries: _____

☐ Serious injuries or illnesses, visits to Emergency Room. Reason & Date: _____

☐ Head Injuries (loss of consciousness?) _____

☐ Lead poisoning, level if known: _____

☐ Trouble breathing, coughing or asthma: _____

☐ Skin problems or rashes: _____

☐ Seizures, staring spells: _____

☐ Vision problems or wears glasses: _____

☐ Ear (PE) tubes or hearing problems: _____

☐ Teeth: One or more cavities: _____

☐ Eating, stomach concerns or constipation: _____

☐ Mental health concerns such as anxiety, depression or attention concerns? _____

☐ Adopted, If Yes, at what age: _____

☐ Problems during pregnancy or birth? _____

☐ Born more than three weeks early or late _____ # weeks at birth. Child's Birth Weight: _____

☐ At birth, stayed in the hospital longer than mother, reason: _____

☐ Is it possible that before you knew you were pregnant you: ☐ drank alcohol ☐ smoked cigarettes

☐ used street drugs ☐ took prescription medication (list) _____

Please List any other concerns: _____

Please check any Family Health problems (child's parents or siblings):

☐ Attention problems	☐ Vision Problems	☐ Diabetes
☐ Allergy	☐ Learning Problems	☐ Growth Problems
☐ Asthma	☐ Mental Health Disorders	☐ Epilepsy/Seizures
☐ Deafness/Hearing	☐ Sickle Cell Anemia/Trait	☐ Other Health Problems

CHILD'S DAILY ROUTINES

_____Sleeps at _____PM. Wakes up at _____AM.

☐ Has difficulty falling/staying asleep

☐ Takes a nap: from_____ to _____

☐ Gets 60 minutes or more of exercise each day

☐ Is NOT able to/does NOT get 60 minutes of exercise

____ TV/Video Game/Screen Time: hours per day

Every day eats some food from the good groups:

☐ 5-9 servings fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

☐ 3 servings calcium rich foods: milk, cheese, yogurt, soymilk, tofu

☐ 2-3 serving iron rich foods: fish, poultry, meat, beans, legumes, eggs

☐ 3 or more servings: Whole Grains: whole wheat bread, cereal, brown rice, tortillas, crackers, pasta

☐ More than one serving of sweets, fruit drinks or junk food each day

In the past 12 months, we worried whether our food would run out before we could by more ☐ Yes ☐ No

In the past 12 months, the food we bought didn't last and we didn't have money to get more ☐ Yes ☐ No

HOME SAFETY

Current Housing Situation:

☐ Renting or Homeowner ☐ Doubled up with friends or family ☐ Hotel or Motel

☐ Emergency Shelter/Transitional Housing ☐ Unsheltered (cars, parks, and campgrounds, temporary)

Does your child live or play in a home or building built before: ☐ 1978 ☐ Remodeled in the last 5 years?

Does anyone at home or who cares for your child: ☐ Use tobacco/smoke ☐ Use alcohol ☐ Have a gun (use safety lock)

Do you have concerns that your child is exposed to: ☐ Violence ☐ Street Drugs ☐ Unsafe Conditions

Do you and/or your child use/have the following:

☐ Car Seats ☐ Bike Helmets ☐ Smoke Detector ☐ Carbon Monoxide Detector

Learning

☐ My child learned to do things at the same age as other children (sit, stand, walk, toilet trained, ect.)

If not, please explain: _____

My child needs help with: ☐ Toileting ☐ Activity/Mobility ☐ Dressing ☐ Nutrition/Eating (Help to Eat Oranges? Milk?)

Other: _____

Please check any of the following:

☐ Says numbers 1 to 10

☐ Has trouble speaking or hard to understand

☐ Has trouble being understood by others

☐ Seems clumsy when using hands

☐ Understands other people

☐ Able to follow directions

☐ Plays in a variety of ways

☐ Walks or runs poorly (falls)

PARENT CONSENT
CHILD HEALTH & DEVELOPMENTAL SCREENING

Child's Name	Birth Date
Parent's Name	(For Office use) Child's MARSS ID OR Record no.

A. This screening includes:

- ❖ Review of your child's immunization record
- ❖ Check of your child's growth such as height and weight
- ❖ Tests for possible hearing problems
- ❖ Tests for eye health, including how well your child can see
- ❖ Review of any other factors that might interfere with your child's health, growth, development, or learning
- ❖ Check of your child's development
- ❖ Your report on your child's growth and learning
- ❖ Information about your child's health care and insurance
- ❖ Information about community resources and programs based on your child's or family's needs

B. If this screening is a Child and Teen Checkups, Head Start, or other equivalent screening, it may also include:

- ❖ Check of your child's present, past, or other family health
- ❖ Check of your child's pulse, respirations, and blood pressure
- ❖ Unclothed physical screening of your child's skin, head, eyes, ears, nose, throat, neck, chest, heart, lungs, abdomen, genitals, arms, legs, spine, and muscles
- ❖ Check of your child's teeth, gums, and mouth
- ❖ Blood tests for anemia
- ❖ Blood test for lead
- ❖ Dental Assessment, triage, and referral by calibrated Dental Hygienist at Screening
- ❖ Apply fluoride varnish
- ❖ Other: _____

This screening **does not** replace on-going care from your health care provider or dentist.

Child & Parent Rights, Obligations, and Assurances

1. The standards for screening are the same for every child regardless of race, income, creed, sex, national origin, or political beliefs.
2. Screening is required for your child's entry into public school kindergarten or first grade. This requirement is met if your child has participated in a screening through Head Start, Child and Teen Checkups, or equivalent screening through another provider that includes all required ECS components within the past year. The screening summary results must be given to your child's school district.
3. Screening is not required for your child's entry into kindergarten or first grade if you are a conscientious objector to screening.
4. You have the right to refuse any of this screening for your child and still receive any of the other screening parts.
5. You have the right to refuse referral for assessment, diagnosis, and possible treatment for your child.
6. Your child's medical assistance eligibility or eligibility in any other health, education, or social service programs will not be affected if you refuse this screening or any parts of this screening.

I give permission for the Child Health & Developmental Screening checked below for _____
(Child's Name)

Check One (X)

____ Complete screening as described in A & B above.

____ Screening described above except: _____

_____ _____ _____
Parent/Guardian Signature Date Relationship to Child

Revised 05/17/2018

INFORMATION, COLLECTION, USE & RELEASE CONSENT
CHILD HEALTH & DEVELOPMENT SCREENING

Child's Name:	Birth Date:
Parent/Guardian Name:	Child's MARSS ID or Record No. (For Office Use)

Northwest Community Action Head Start/Early Head start (this organization) uses information from the Child Health and Development Screening to identify any possible problems that might interfere with your child's health, growth, development or learning. Under Minnesota law screening results are classified as private data. The results cannot be released or discussed with anyone without your consent. If you refuse to release this information, it will not affect your child's eligibility for medical assistance or any other health, education, or social service program.

Information may be used for the following purposes:

1. To obtain follow-up services for your child after the screening.
2. To arrange for further evaluation or assessment of your child's health, growth, development, or learning.
3. To fulfill the requirements for your child's entrance into public school.
4. To evaluate screening programs by the Minnesota Department of Health, Minnesota Department of Education, and/or the Department of Human Services. Your Child's name will not be identified in any evaluation results.

Your signature indicates that you *have* read, understand, and agree that the information can be used as stated above.

CONSENT TO RELEASE INFORMATION

I hereby authorize release of my child's screening information to the following checked programs or services for the purpose of evaluation assessment, diagnosis, follow-up, and/or programming. (Please provide names and addresses where available.)

Check (X) any persons/agencies that you wish to receive screening information about your child.

	Child Care Provider
	Dentist (Name)
	Early Childhood Family Education (ECFE)
	Early Childhood Special Education
	Follow Along Program
X	Northwest Head Start/Early Head Start
	Health Care Provider (Medicare Clinic)
	Interagency Early Intervention Committee (IEIC)
	Mental Health Agency
	Public Health Agency/WIC
	School District (Name)
	School Readiness
	Other (regionally specific programs)

□ Understand Information □ Authorize release of information

Parent/Guardian Signature _____ Date _____ Relationship to child _____

Revised 3/26/2020

Northwest - Head Start/Early Head Start
312 N. Main Street, P.O. Box 67, Badger, MN 56714
1-800-568-5319/218-528-3227
218-528-3259 (Fax)
Consent for Release/Exchange of Information

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

Address: _____ City, State, Zip: _____

UNDERSTANDING/PURPOSE OF DISCLOSURE:

I understand that the information to be accessed and/or exchanged regarding my child/family will be treated as private data under the Minnesota Government Data Practices Act. This means that the information will be safeguarded as required by law. Information may be released/accessed/exchanged without my further signed consent unless I should revoke my consent. **(Purpose)** I understand that this information is being shared to meet program performance standards, to plan comprehensive services and coordinate service delivery.

I Authorize:

_____

_____

_____

_____

_____

To Release to:

Head Start/Early Head Start

NW Community Action

PO Box 67

312 North Main St

Badger, MN 56714

Information Requested:

- ☐ Health History
- ☐ Physical Exam
- ☐ Immunizations
- ☐ LAB (Ua/Hct/Hgb)
- ☐ Vision
- ☐ Hearing
- ☐ Heights & Weights
- ☐ Blood Lead
- ☐ Developmental Screening Results
- ☐ Assessment Information
- ☐ IEP/IFSP/IIIP
- ☐ Mental Health Screening
- ☐ Other: _____

1. I understand that treatment, payment, enrollment, or eligibility of benefits by a covered entity may not be conditioned on obtaining the individual authorization.
2. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Re-disclosure of this information will no longer be protected under the HIPAA privacy rule.
3. I understand that my consent includes both past and future records and terminates one year from date of signature unless I choose to revoke it earlier in writing, by notifying the providing organization, except to the extent action has already been taken in reliance on it.
4. I direct that a photocopy, email, or fax copy of this authorization be granted the same authority as the original.

_____ _____

Parent/Guardian Signature Month/Day/Year

_____ _____

Northwest Head Start/Early Head Start Staff Signature Month/Day/Year

(Revised 05/01/2019)

NWCA Head Start/Early Head Start
Vision Screening Worksheet

Child's Name	Age (Yrs/Mo)	Screening Date	Rescreen Date

VISION HISTORY AND QUESTIONS – ALL AGES

	YES	NO
1. Do you suspect anything is wrong with your child's eye/vision?		
2. Have the child's siblings, parents, grandparents, aunts, uncles, or first cousins had eye/vision problems that required treatment *before entering school*?		
3. Was the child born premature or had retinopathy of prematurity?		
4. Is there a family history of congenital cataracts, retinoblastoma, metabolic or significant development delay?		
5. Have you observed any problems or change in the whites, pupils, lids, lashes or the area around the eyes?		
6. Have you noticed an abnormal sensitivity to light, nausea or dizziness or signs/complaints of headaches?		
7. Do both of the child's eyes appear the same in pictures?		
8. Have you noticed any of the following:		
a. Turning of one eye (in, out, up or down)? Either occasional or always.		
b. Poking at the eyes or frequent rubbing?		
c. Poor eye contact?		
d. Covering or closing an eye when looking at an item of interest?		
e. Squinting, blinking or unusual tearing?		
f. Inaccuracy in reaching for item of interest?		

VISION SCREENING

Spot Vision Screener ☐ **Pass** ☐ **Refer**

Does child have glasses or contacts?
Wearing them during screening?

Problem Noted:

	SCREEN YES	SCREEN NO	RESCREEN YES	RESCREEN NO
A. External Inspection (Birth and older) WIPL				
B. Observation (2 months – 3rd grade)				
C. Corneal Light Reflection (2 months – 3rd grade)				
D. Cross Cover Test (4months – 3rd grade)				
E. Visual Acuity (age 3 as early as possible)				
age 3-5 yr Screen R 10/_____ L 10/_____				
Re-Screen R 10/_____ L 10/_____				
F. EOM/Fix and Follow Binocular (2 months until V.A.)				
G. EOM/Fix and Follow Monocular (2 months until V.A.)				
H. Pupillary Light Response (birth until V.A.)				
I. Retinal Reflex (birth until V.A.)				

NWCA Head Start/Early Head Start
Hearing Screening Worksheet

Child's Name	Age (Yrs/Mo)	Screening Date	Rescreen Date

HEARING HISTORY – ALL AGES

	YES	NO
1. Is there a concern that this child has a hearing problem?		
2. Are there any *childhood hearing* problems in the family of either the child's mother or father?		
3. Does the child have a history of middle ear disease and/or tubes?		
4. Has the child had a head trauma with concussion, skull fracture or loss of consciousness?		
5. Has the child ever been hospitalized with a serious illness (i.e. kidney, meningitis)?		

HEARING SCREENING

	SCREEN		RESCREEN	
	YES	NO	YES	NO
OAE				
Problem Noted:				
A. External Inspection				
B. Internal Inspection/Otoscopy (all ages)				

PURE TONE: [Note: WNL = Within Normal Limits]

Screen: ☐ Head Cold ☐ WNL ☐ Rescreen

Level (dB)	25	20	20	20
Frequency (Hz)	500	1000	2000	4000
Right Ear				
Left Ear				

Re-Screen: ☐ Head Cold ☐ WNL ☐ Rescreen

Level (dB)	25	20	20	20
Frequency (Hz)	500	1000	2000	4000
Right Ear				
Left Ear				

NWCA HEAD START/EARLY HEAD START
PO Box 67 • Badger, MN 56714 • Office: (218) 528-3227 or (800) 568-5317 • Fax: (218) 528-3259

Head Start Oral Health Form – Children

Patient Information

Child's Name _____ Date of Birth _____ Parent's/Guardian's Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

***Family Dental Provider Name: _____ Date of last visit: _____

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)
Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services
Examination: ☐ Yes ☐ No
X-Rays: ☐ Yes ☐ No
Risk Assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride Varnish: ☐ Yes ☐ No
Dental Sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance
☐ Yes ☐ No

Referral to Specialty Care
☐ Yes ☐ No
_____ (please specify specialist)

Restorative/Emergency Care
Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency: ☐ Yes ☐ No
Other: _____ *(please specify)*

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next Exam Date: _____
More Appointments needed for treatment? ☐ Yes ☐ No
If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Oral Health Provider's Contact Information and Signature

***If the estimated cost of services to be provided exceeds $250.00, contact NWCA HS/EHS for further authorization.**

Billed To: _____ Amount $_____ Date: _____

Provider Name *(please print)* _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Date _____