Expect great things.

Pittsburgh Public Schools

Child's Name: _____

Child's Date of Birth: _____

Location: _____

The following completed forms and information are ***mandatory*** to enroll your child:

- Physical Examination - completed by physician
- Immunizations - completed by physician
- Dental Form - completed by dentist
- Copy of Child's Birth Certificate
- Proof of Income – copies of paystub, W2, DPA printout,etc..
- Two Proofs of Residence

Please return all forms to Center Director.

Early Childhood Education Program

1398 Page St
Pittsburgh, PA 15233

earlychildhood@pghboe.net
Phone: 412-529-4291
Fax: 412-325-0702

Parent Hotline:

412-529-HELP (4357)

www.pghschools.org

Application Status _____ Pending _____ Waitlisted _____

Application Date_____ Early Head Start Entry _____ PPS Early Childhood Application

Enroll Date _____ Re-enrollment Date_____

Child's/Applicant's Legal Name (Last)	(First)	Preferred Site/Location:
		1
		2
		3

Gender Male Female	Date of Birth	Primary Language: Secondary Language:	Does your child have an IEP? ___Yes ___No

Race: (*Check all that apply*) ____ Asian ____ African American ____ White ____ Hispanic
____American Indian or Alaska Native ____Hawaiian/Pacific Islander ____Other: _____

Does your child have a sibling(s) in the Pittsburgh Public School System? ____ Yes ____No	If Yes, Child's Name(s):	School and Grade

In what type of setting is the child living now?

_____ In adequate housing, child's needs are met in a home environment	_____In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings
_____Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason	_____ Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings.
_____In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations	_____ In an emergency or transitional shelter

Type of Health Insurance for applicant _____Medicaid _____CHIP _____Private _____Military _____Other _____None

CHILD'S MEDICAID ELIGIBILITY STATUS _____Eligible _____Not Eligible _____Potentially Eligible

Primary Health Coverage (Health Insurance)	Secondary Health Coverage (Health Insurance)

Primary Parent/Guardian Name:	Gender Male Female	Date of Birth	Highest Grade Completed	*Employment Status* ____Student ____ Disabled ____Unemployed ____ Retired ____Full Time ____Part Time

Race: (Check all that apply) ____ Asian ____ African American ____ White ____ Hispanic ____American Indian or Alaska Native ____Hawaiian/Pacific Islander ____Other:

Relationship to child	Living Address: Zip Code	EMail Address :

Phone: ( ) home / work / cell / other	Phone: ( ) home / work / cell / other

Secondary Parent/Guardian Name:	Gender Male Female	Date of Birth	Highest Grade Completed	*Employment Status* ____Student ____ Disabled ____Unemployed ____ Retired ____Full Time ____Part Time

Race: (Check all that apply) ____ Asian ____ African American ____ White ____ Hispanic ____American Indian or Alaska Native ____Hawaiian/Pacific Islander ____Other:

Lives with Family? ____YES ____NO	Relationship to child	Living Address:	EMail Address :

Phone: ( ) home / work / cell / other	Phone: ( ) home / work / cell / other

TANF (cash) _____YES _____NO
TANF (food stamps/SNAP) ____YES ____NO ← *Complete for Primary Care Giver* → WIC _____YES _____NO

Parent(s)/Guardian(s) on active Military _____YES _____NO If yes Branch _____	Referred for services by a child welfare agency ___YES ___NO
Parental Status (circle): One Parent Household Two Parent Household Foster Parent Other_____	# in Family _____ # of children _____ # Age 0-3_____ # Age 4-5_____ # in Household supported by you_____

Child's Name _____ Date of Birth _____

EMERGENCY INFORMATION

Name	Relationship to Child			Release To? ____YES ____NO
Address	City	State	Zip	Phone ___Home /___Cell /___Work ( )
Name	Relationship to Child			Release To? ____YES ____NO
Address	City	State	Zip	Phone ___Home /___Cell /___Work ( )
Name	Relationship to Child			Release To? ____YES ____NO
Address	City	State	Zip	Phone ___Home /___Cell /___Work ( )

CHILD'S PHYSICIAN INFORMATION

Physician Name:		Phone		
Practice Name	Address	City	State	Zip

CHILD'S DENTIST INFORMATION

Dentist Name:		Phone		
Practice Name	Address	City	State	Zip

ADDITIONAL PEOPLE RESIDING IN HOUSEHOLD THIS INCLUDES ALL CHILDREN AND ADULTS

LAST NAME	FIRST NAME	DOB	GENDER	GRADE	RELATIONSHIP to CHILD

INCOME INFORMATION WORKSHEET FOR PARENT/GUARDIAN - MUST INCLUDE SUPPORTING DOCUMENTATION

FAMILY MEMBER	*SOURCE	AMOUNT	**x	ANNUAL INCOME
		$		$
		$		$
		$		$
		$		$
			Total yearly income of family	$

*Source: PEN-Pension SSI-SSI SS-Social Security TAN-Tanf E-Employed F=Foster CS=Child Support U=Unemployment

**Twice a month x 24 = Annual Income Monthly x 12 = Annual Income Weekly x 52 = Annual Income Every 2 weeks x 26 = Annual Income

Certification: *I certify that this information is true. If any part is false. my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature X_____ Date _____

Child's Name_____ DOB:_____

Child's Health Record

(To be completed by Parent)

HEALTH HISTORY

Pregnancy/Birth	Yes	No	Explain "Yes" Answers
1. Did mother have any problems during pregnancy or delivery?			
2. Was child born more than 3 weeks early or late?			
3. What was child's birth weight? Please write in "yes" column.			
4. Was anything wrong with the child at birth or in the nursery?			
5. Is the mother pregnant now?			
6. If so, is she receiving prenatal care?			

Hospitalization/Illnesses	Yes	No	Explain "Yes" Answers
7. Has your child ever been hospitalized or operated on?			
8. Has your child ever had accidents? (broken bones head injuries burns, poisoning)?			
9. Has child ever had a serious illness?			

10. **Past Illnesses: (Check all that apply and state how often)**

☐ Accidents ____	☐ Heart Murmur ____	☐ Strep Throat ____
☐ Allergies ____	☐ Hernia ____	☐ Scarlet Fever ____
☐ Asthma ____	☐ Lead Poisoning ____	☐ Tonsillitis ____
☐ Chicken Pox ____	☐ Kidney Problems ____	☐ Pneumonia ____
☐ Ear Infection ____	☐ Measles ____	☐ Tuberculosis (TB) ____
☐ Elevated Lead Levels ____	☐ Meningitis ____	☐ Seizures ____
☐ Eczema ____	☐ Polio ____	☐ Sickle Cell Disease ____
☐ Heart Problems ____		

11. Allergies	Reactions
Foods:	
Medications:	
Other:	

	Yes	No	Explain "Yes" Answers
12. Does your child have difficulty seeing? (squinting, cross eyes, looks too closely at books)			
13. Does your child have problems with his/her ears or hearing? (frequent earaches, discharge, favoring one ear over the other?)			
14. Is your child currently taking any medications? If yes, write name of medication in "Yes" column. Will it need to be taken during class time?			

15. **Developmental History (Please note actual ages or if child seemed normal compared to other children)**

Rolled over _____ Sat alone _____ Crawled _____
Few words _____ Sentences _____ Talked _____
Walked _____ Toilet Trained _____

16. **Concerns: Do you have any special concerns about your child's:(circle all that apply)**

Health Speech/Languange Behavior Hearing Vision Other:_____

Child's Name: _____ **DOB:** _____

Center: _____

Nutrition
(To be completed by parent)

Dietary Habits

1. What kind of foods does your child especially like? _____

2. Are there any foods your child dislikes? _____

		Yes	No	
3.	Does your child have any food allergies? If yes, list them in "Comments" section			3
4.	Is your child on a special diet? If yes, is this diet prescribed by a doctor? If yes, describe it in the "Comments" section below?	* * *		4
5.	Is there any food your child should not eat for religious or personal reasons? If yes, list them in the "Comments" section below.	*		5
6.	Does your child take vitamins and mineral supplements? If yes, what kind? Do they contain Iron? Do they contain Fluoride? Were they prescribed by a doctor?	* *		6
7.	Has there been a big change in your child's appetite in the last month?	*		7
8.	Does your child take a bottle?	*		8
9.	Does your child eat or chew things that aren't food?	*		9
10.	Does your child have trouble chewing or swallowing?	*		10
11.	Does your child often have: Diarrhea? Constipation?	* *		11
12.	Do you have any concerns about what your child eats?	*		12
	Comments ***Some Yes answers may require follow-up. Please explain or provide additional comments in this section.**			

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Pittsburgh Public Schools

Early Childhood Program
Health Consent Form

Child's Name: _____ Date of Birth: _____

Center: _____

I, (Parent/Guardian)_____, give permission for

(Child's Name)_____to receive the following health services:

Please initial next to each service for which you are giving consent. These services will not be conducted without this authorization form:

- ☐ Permission for staff to provide first aid to your child and if necessary, call 911 for Emergency Medical/Dental Treatment and Transportation of your child by first responders (EMS) to a source of emergency treatment.
- ☐ Behavioral Observation
- ☐ Development Screening
- ☐ Hearing Screening
- ☐ Vision Screening
- ☐ Height and Weight Measurement
- ☐ Speech/Language Screening

I understand that these screenings are a requirement of the Early Childhood Performance Standards and that I will be informed of any results which indicate the need for further professional evaluation. Otherwise, a health summary will be provided within the program year. I understand that I have the right to be present during any screening or examination. I understand that I have the right to refuse to participate in any screening or examination. If I refuse these services, I must obtain the above screening or examination and provide documentation to the Early Childhood Program within 30 days of the date of refusal. Otherwise, my child will be placed on the waiting list until proof that these services were obtained is provided.

_____ _____

Parent/Guardian signature Date

_____ _____

Verifying Staff Signature Date

Early Childhood Education Programs

Sherry LaFrance,
Health Coordinator

Phone: 412-529-8015
Fax: 412-325-8745
Email: slafrance1@pghschools.org

Parent Hotline:
412-529-HELP (4357)

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

Parents may write immunization dates; health professional should verify and complete all data.

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

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Pittsburgh Public Schools

Pittsburgh Public Schools Early Childhood Program

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

(To be completed by parent and returned to Early Childhood Health Office to forward to medical provider)

Child's Name: _____ Date of Birth: _____

Name of Medical Provider/Doctor _____

Address of Medical Provider/Doctor _____

I, (Name of Parent/Guardian) _____, hereby request and authorize the medical doctor/provider to release the following information on my child compiled during the period of **1/1/2017 to 8/30/23** (*Approximate date of services):*

_____ Dental Exam
X **Physical Exam/Immunizations**
X **Lead & Hemoglobin**
_____ Physician Notes/Orders
_____ Medical History
_____ Discharge Summary
_____ Other: _____
X **Ongoing verbal contact between agency providers and Pittsburgh Public School Staff for the duration of the education program**

HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the records indicated will be released through this authorization unless otherwise indicated, Do Not Release.

These records will be used for required documentation for enrollment in program. I understand the following:

- That my or my child's records will not be released or obtained by Pittsburgh Public Schools unless permission is provided for herein as evidenced by the signature on this authorization form.
- That the release of my or my child's records will be for the purpose stated on this form and only those items checked off will be released.
- That the records released by the Pittsburgh Public Schools may possibly be re-disclosed by the facility/agency/person and that the Pittsburgh Public Schools and its staff have no responsibility or liability as a result of the re-disclosure and that such information would no longer be protected by the Privacy Rule.
- That the disclosed information will no longer be protected by HIPPA or privacy act, and the releasing facility will not be responsible for the disclosure of the information.
- That this authorization is valid for one year unless documented otherwise.
- That I may revoke this authorization at any time by notifying, in writing, the party responsible for maintaining records, except for the information already disclosed.
- That the Pittsburgh Public Schools will not condition enrollment or eligibility for my or my child's educational services on whether I sign this authorization or not.
- That I am entitled to a copy of this Authorization form.

I have read this authorization and understand its contents and purpose.

Parent/Legal Guardian: _____ Date: _____

Because of the sensitive nature of this information, it will be treated with complete confidentiality. A copy of this authorization shall be considered valid.

Dear Medical Provider: Please forward health records by mail, e-mail or fax to:
Sherry LaFrance RN, CSN, Early Childhood Health Coordinator
Pittsburgh Public Schools, Early Childhood Program
Crescent Early Childhood Center, 8080 Bennett Street, Pittsburgh, PA 15221
Email address: slafrance1@pghschools.org Fax: (412) 325-8745

Early Childhood Education Programs
Sherry LaFrance,
Health Coordinator
Phone: 412-529-8015
Fax: 412-325-8745
Email: slafrance1@pghschools.org
Parent Hotline:
412-529-HELP (4357)

Expect great things.

Pittsburgh Public Schools

Pittsburgh Crescent Early Childhood Center

8080 Bennett Street
Phone: 412-529-8015
Fax: 412-325-8745

Dear Health Care Provider:

The Pittsburgh Public Schools Early Childhood Program is required to obtain documentation that a blood lead test and hemoglobin or hematocrit screening was administered to all enrolled children. The State of Pennsylvania's EPSDT standards require all children to be screened for lead at 9-11 months; again at 24 months. An anemia screening is required between 9-12 months. Therefore, we are requesting that you record the most recent dates and results of these screenings.

If your patient has not received these tests, please complete these screenings as soon as possible and mail or FAX the results to me. You can find the address and fax number above. If you have any questions, please contact me at (412) 529-8015.

Sincerely,

Sherry LaFrance, RN, CSN
Early Childhood Health Coordinator
PPS Early Childhood Program

Child's Name: _____

Birth Date: _____ EC Center: _____

Test or Screening	Date	Result
Lead Test		
Hemoglobin or		
Hematocrit		

Signature: _____ Title: _____

Practice name: _____

Early Childhood Education Programs
1398 Page Street
Pittsburgh, PA 15233
Phone: 412-529-4291
Fax: 412-325-0702
nail: earlychildhood@pghboe.net
Parent Hotline:
412-529-HELP (4357)

Expect great things.

Pittsburgh Public Schools

Pittsburgh Public Schools Early Childhood Program
AUTHORIZATION TO RELEASE/OBTAIN INFORMATION
(To be completed by parent and returned to Early Childhood Health Office to forward to medical provider)

Child's Name: _____ Date of Birth: _____

Name of Medical Provider/Dentist _____

Address of Medical Provider/Dentist _____

I, (Name of Parent/Guardian) _____, hereby request and authorize the medical doctor/provider to release the following information on my child compiled during the period of **1/1/2017 to 8/30/23** (*Approximate date of services):*

__X__ **Dental Exam**
_____ Physical Exam/Immunizations
_____ Lead & Hemoglobin
_____ Physician Notes/Orders
_____ Medical History
_____ Discharge Summary
_____ Other: _____
X Ongoing verbal contact between agency providers and Pittsburgh Public School Staff for the duration of the education program

HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the records indicated will be released through this authorization unless otherwise indicated, Do Not Release.

These records will be used for required documentation for enrollment in program. I understand the following:

- That my or my child's records will not be released or obtained by Pittsburgh Public Schools unless permission is provided for herein as evidenced by the signature on this authorization form.
- That the release of my or my child's records will be for the purpose stated on this form and only those items checked off will be released.
- That the records released by the Pittsburgh Public Schools may possibly be re-disclosed by the facility/agency/person and that the Pittsburgh Public Schools and its staff have no responsibility or liability as a result of the re-disclosure and that such information would no longer be protected by the Privacy Rule.
- That the disclosed information will no longer be protected by HIPPA or privacy act, and the releasing facility will not be responsible for the disclosure of the information.
- That this authorization is valid for one year unless documented otherwise.
- That I may revoke this authorization at any time by notifying, in writing, the party responsible for maintaining records, except for the information already disclosed.
- That the Pittsburgh Public Schools will not condition enrollment or eligibility for my or my child's educational services on whether I sign this authorization or not.
- That I am entitled to a copy of this Authorization form.

I have read this authorization and understand its contents and purpose.

Parent/Legal Guardian: _____ Date: _____

Because of the sensitive nature of this information, it will be treated with complete confidentiality. A copy of this authorization shall be considered valid.

Dear Medical Provider: Please forward health records by mail, e-mail or fax to:
Sherry LaFrance RN, CSN,.Early Childhood Health Coordinator
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Early Childhood Education Programs
Sherry LaFrance,
Health Coordinator
Phone: 412-529-8015
Fax: 412-325-8745
Email: slafrance1@pghschools.org
Parent Hotline:
412-529-HELP (4357)

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

1. IS THE CHILD NOW RECEIVING: *If "yes" include length of time receiving fluoride*
   - Topical Fluoride Application? No ____ Unknown ____ Yes ____
   - Fluoridated water? No ____ Unknown ____ Yes ____
   - Fluoride Supplement diet? (tablets _____, liquid _____) No ____ Unknown ____ Yes ____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART I. TO BE COMPLETED BY HEAD START STAFF

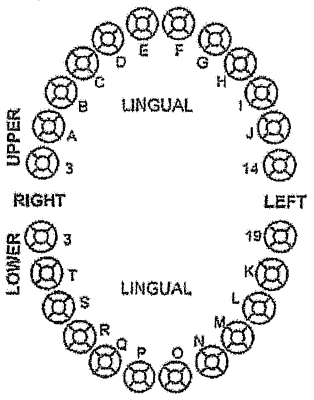
3. CHILD (____ HAS, ____ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name _____
4. CHILD (____ IS, ____ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name _____
5. CHILD (____ HAS, ____ HAS NOT) RECEIVING MEDICATION.
   Type _____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	____	____	Liver Dis.	____	____
Asthma	____	____	Rheumatic Fever	____	____
Bleeding	____	____	Sickle Cell Dis.	____	____
Diabetes	____	____	Other (List Below)	____	____
Epilepsy	____	____	_____		
Heart/Vascular Dis.	____	____	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider _____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party) _____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing ( ), decayed ( ), or filled ( ), indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surface	Description of Work	Treatment Approved	Date Service Performed MO. DAY YR.	A.D.A. Procedure Number	Actual Charges (Fee)

11. DENTAL NEEDS (Check one or more and return 3 copies to Head Start after first visit).
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits _____. Approximate cost _____.

12. CHILD HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (_____ is, ____is not) complete. If not, explain here, as well as items checked.
   _____
   _____

   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietry problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs Fluoride supplement

I certify that I have completed the service(s) listed in Part II, item 10, and that itemized charges do not exceed my usual and customary fees.

Signature _____ Date _____

NATIONAL CENTER ON
Early Childhood National Centers
Early Childhood Health and Wellness

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 _____

This practice is the child's dental home: Yes No

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 care:	Yes	No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature / Date _____ Date of service (Exam date) ☆

This document was prepared under grant #9OHC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness.

Child's Name: _____ **DOB:** _____

Center: _____

Nutrition
(To be completed by parent)

Dietary Habits

1. What kind of foods does your child especially like? _____

2. Are there any foods your child dislikes? _____

		Yes	No	
3.	Does your child have any food allergies? If yes, list them in "Comments" section			3
4.	Is your child on a special diet? If yes, is this diet prescribed by a doctor? If yes, describe it in the "Comments" section below?	* * *		4
5.	Is there any food your child should not eat for religious or personal reasons? If yes, list them in the "Comments" section below.	*		5
6.	Does your child take vitamins and mineral supplements? If yes, what kind? Do they contain Iron? Do they contain Fluoride? Were they prescribed by a doctor?	* *		6
7.	Has there been a big change in your child's appetite in the last month?	*		7
8.	Does your child take a bottle?	*		8
9.	Does your child eat or chew things that aren't food?	*		9
10.	Does your child have trouble chewing or swallowing?	*		10
11.	Does your child often have: Diarrhea? Constipation?	* *		11
12.	Do you have any concerns about what your child eats?	*		12
	Comments ***Some Yes answers may require follow-up. Please explain or provide additional comments in this section.**			

Family Partnership Agreement

Student's Name: _____ Parent /Guardian Name _____
Date Completed: _____ Family Services Specialist _____
Classroom: _____

Please choose a goal from the following list. Please place a **1** for each goal you would like to work on for this school year.

FAMILY WELL-BEING	Score 1 or 0
Employment – job skills and job training	
Income management, financial security and budgeting	
Medical and dental care	
Safe and efficient housing	
Physical and mental wellness	
Affordable access to food, meal preparation, healthy living	
Transportation- access/affordable/reliable	
POSITIVE PARENT-CHILD RELATIONSHIPS	Score 1 or 0
Managing my child's behavior	
Spending quality time with my child	
Actively involved with my child	
Developing routines for my child	
FAMILIES AS LIFELONG EDUCATORS	Score 1 or 0
Knowledge and skills to teach my children	
Knowledge and understanding of child development	
Communicating with my child's teacher	
Supporting learning at home	
Supporting educational plans for my child	
Reading with my child and other educational activities	
FAMILIES AS A LEARNERS	Score 1 or 0
Basic life skills (i.e. cooking, budgeting, socialization, time management)	
Educational level-continuing or furthering education	
Reading and writing skills	
Communication skills (ability to express yourself positively and effectively)	
FAMILY ENGAGEMENT IN TRANSITIONS	Score 1 or 0
Understanding the transition process	
Comfortable with new teachers and program	
Preparation toward elementary school	
Setting goals for my child	
FAMILY CONNECTIONS TO PEER AND COMMUNITY	Score 1 or 0
Immediate and/or extended family support system	
Connection/support with local school	
Connected to other parents and families with young children	
Connections/support from other community agencies and services	

EARLY CHILDHOOD EDUCATION PROGRAM

FAMILY SUPPORT FORM

Parent/Guardian Name: _____

Child's Name: _____

Do you need assistance in any of the following below? If yes, please explain

	Yes	No	Explain "Yes" Answers
1. Emergency			
2. Crisis Assistance			
3. Food			
4. Housing			
4A During the past six months, have you at any time been homeless or lived in emergency shelter?			
5. Clothing			
6. Transportation			
7. Mental Health Services			
8. Literacy or Education			
9. English as a Second Language			
10. Adult Education			
11. Job Training			
12. Substance Abuse Prevention/Treatment			
13. Child Abuse and Neglect Services			
14. Domestic Violence Services			
15. Child Support Assistance			
16. Health Education (including Prenatal)			
17. Assistance to Families of Incarcerated			
18. Parenting Education			
19. Marriage Education			
20. Health problems or disabilities			
21. Are you involved with any other community agencies that can provide assistance? If yes, what is the name of group?			

Family Partnership Agreement

FAMILIES ADVOCATES AND LEADERS	Score 1 or 0
Involvement in my child's education	
Volunteering in my child's classroom and school	
Volunteering in my community	
Comfortable making decisions about my child's health	
Confident in speaking up for my child and family	
Awareness of state and federal issues that impact young children and families	

Expect great things.

Pittsburgh Public Schools

Family Partnership Agreement

Student name_____

Parent /Guardian name(s)_____

In our efforts to better serve you and your family we would like to establish a relationship with you. This family Goal Assessment provides the opportunity for the program to learn about and support your family in response to your interests, goals, strengths and needs. This document will be reviewed three times a year in order to better assist you and work together to achieve your personal goals and work on the program goals.

Family goals (Goals you have for yourself and/or your family)

_____

_____

_____

_____

_____

What are the actions/steps that you are taking to achieve your goals?

_____

_____

_____

_____

_____

The Family Services Specialist will assist you in achieving your goals in the following ways. (To be determined with the Family Services Specialists)

_____

_____

_____

_____

_____

Progress on goals

Notes

Program Expectations: Check if you need information or support with any of these.

☐At least 90% attendance

☐Compliance with drop off and pick up policies

☐Compliance with Early Childhood Policy and Procedures

Parent/Guardian Signature _____

Initial Date_____ Review Date_____ Final Date _____

Staff Signature _____

Zero Income Declaration Letter

Name (Parent/Guardian) _____

Name (Child) _____

Program Name _____

Program Year _____

I am signing this letter to declare that I currently do not have any income from any source. My financial support comes from (please describe):

☐ I agree to notify the above program about changes in my income within 30 days of the change.

☐ I certify that the information submitted is accurate and true to the best of my knowledge. I understand that by completing, signing, and dating this form, I declare I have no household income and that the information I am providing is correct. I understand that providing false information may result in denial of services.

_____ _____

Parent Signature Date

_____ _____

Reviewer Signature Date