Atencion Padres de Familia
Esta carta es para el doctor de su hijo(a)

Por favor firme en el espacio proporcionado para la firma de los padres "Parent / Guardian Signature." Al firmar ésta carta, usted autoriza al doctor a dar – a Head Start – los resultados del examen de su hijo(a). Por favor lleve ésta carta cuando vaya a la cita delo examen para que el doctor complete la información requerida. Le agradecemos mucho su colaboración.

Dear Health Care Professional,

According to **(FEDERAL PERFORMANCE STANDARD: 45 CFR 1304.20(a) (1) (ii) & (A))**

Head Start Federal programs are required, within 90 days of enrollment, to obtain from a health care profession a determination as to whether a child is up-to-date on a schedule of age appropriate preventive and primary heath care. The schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate. This exam must include immunization recommendations issued by the Center of Disease Control and Prevention. **Head Start Performance standards also require a BLOOD LEAD LEVEL SCREENING.**

Head Start follows the law for immunization required for enrollment in Child Care (WAC 388-295-7020).

To comply with performance standard requirements we need providers to complete the attached **Health Appraisal** or send a copy of the child's most current **EPSDT Well Child Exam including Blood Lead Level Results**. Also attached in the parents authorization for "Request for Release of Medical Information"

Thank you for taking the time to complete the information and returning the form to Head Start in a timely manner. Program guidelines require that we keep the information in a confidential child file. If you have any questions, please do not hesitate to call.

Jenny Diaz
Health Services Specialist
735-1062/fax 737-8492

Request for Release of Medical Information

Child's Name/*Nombre del niño*:_____**Birthdate**/*Fecha de nacimiento*:_____

I give my permission for Benton Franklin Head Start and _____
(Physician's/Clinic's Name)

to mutually exchange health information concerning my child.

Parent's/Guardian'sName/*Nombredelpadre*:_____

_____ _____
Parent's/Guardian's Signature/*Firma del padre* Date/*Fecha*

Benton Franklin Head Start
1549 Georgia Ave. S.E. Suite B, Richland, WA 99352
(509) 735-1062 · Fax (509) 737-8492

HEALTH APPRAISAL

Request for Release of Medical Information form signed by parent/guardian accompanies this document.

Child's Name:_____
Birthdate:_____

MEDICAL PERSONNEL ONLY

Date of physical exam: _____	Does child have Iron Deficiency Anemia? ❒ No ❒ Yes
Height:_____ Weight _____	Hct/Hgb Results _____
If overweight, Has child received treatment? ❒ No ❒ Yes	Was child screened for high risk of lead exposure? ❒ No ❒ Yes
Date of next exam:_____	Does child have elevated blood lead levels? ❒ No ❒ Yes
	Lead Level Results _____

1) Are you serving as this child's "Medical Home" or Primary Care Provider?
   ❒ No ❒ Yes

2) Is he/she up to date on a schedule of age appropriate preventative and primary health care including requirements set forth in the EPSDT schedule recommendations issued by CDC?
   ❒ No ❒ Yes

3) Are there any conditions that need accommodations in the classroom, or require follow-up treatment? (eg. asthma, allergies, illnesses, anemia, etc.)
   ❒ No ❒ Yes, please explain under "Comments"

Comments:

_____
Name of Physician or Clinic

_____ _____
Signature of Examining Physician Date

PLEASE MAIL OR FAX (737-8492) COMPLETED FORM TO <u>BENTON FRANKLIN HEAD START</u>