FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

HEAD START

Date:________________

Dear Parents/Guardians:

In compliance with Head Start and childcare licensing regulations, we must make sure that your child and all other children in YMCA of Frederick County Head Start are healthy and safe. To do this, it is necessary to have complete health information on file. **The item(s) marked with an "X" is/are what is needed for your child to be considered for enrollment. Please return needed information to 115 East Church St.- as soon as possible.**

__x___ **PHYSICAL EXAMINATION, completed within the current year**

__ x __ **IMMUNIZATION RECORD** or ___________________________
(specific immunization(s))

__x___ **LEAD (BLOOD) TEST RESULTS or LEAD ASSESSMENT**

__ x__ **HEMATOCRIT/HEMOGLOBIN RESULTS**

__ x___ **BLOOD PRESSURE**

____x____ **TB ASSESSMENT** **1. Complete the TB Assessment Questionnaire and have the doctor review & sign answers.**

Head Start forms may be included for your child's health care provider to complete. These forms must be dated and signed by a licensed health professional. All records will be reviewed and approved by the Head Start Nurse Consultant. Please use the form mailed or given to you.

For children who have no insurance, the Frederick County Health Department offers free immunizations. For more information, call 301-600-3342. The Frederick County Health Department can also assist with application for medical insurance. In addition, Mission of Mercy offers free physical examinations and other services. For information, call 301-631-2670.

Thank you for your prompt attention to this matter. If you have any questions, please call Colleen Ford, 301-378-9140. Fax numbers: 301-378-9127

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

HEAD START

Fecha:________________

Estimados Padres de Familia/ Guardianes:

De acuerdo a las regulaciones de Head Start y de las licencias para Cuidado de Niños nosotros debemos asegurarnos que su hijo y el resto de niños que asisten a YMCA del Condado de Frederick Head Start estén saludables y seguros. Para hacer esto, es necesario de mantener la información de salud de su hijo/a en nuestros archivos y que la misma este actualizada. Lo que se encuentra marcado con una "X" es / son lo que se necesita para que su hijo sea considerado para la inscripción. Por favor devuelva la información necesaria a 115 East Church St. - tan pronto como sea posible.

__x___ EXAMEN MEDICO, realizado durante el presente año

__x___ REGISTRO DE VACUNAS o

____________(especifique la vacuna(s) requeridas)

__x___ RESULTADOS DE LA PRUEBA DE PLOMO o ALUACIÓN DE PLOMO EN LA SANGRE

__x___ RESULTADOS DE HEMATOCRITO Y HEMOGLOBINA

__x___ PRESION SANGUINEA

__x____ EVALUACIÓN DE TB Complete el Cuestionario de Evaluación de la tuberculosis
ıédico revise, responda y firme

Las formas de Head Start pueden ser incluidas para que el médico de su hijo/a pueda completar. Estos formularios deben estar fechados y firmados por un profesional de la salud autorizado. Todos los expedientes serán revisados y aprobados por la Enfermera Consultar de Head Start.

Para los niños que no tienen seguro médico, el Departamento de Salud del Condado de Frederick ofrece vacunas gratis. Por mas información, llame al 301-600-3342. El Departamento de Salud del Condado de Frederick le ayudará llenar la solicitud para obtener seguro médico. Además La Clínica de Mission of Mercy ofrece exámenes médicos gratis y otros servicios. Para más información, llame al 301-631-2670.

Gracias por su pronta respuesta a nuestro pedido. Si Usted tiene preguntas por favor llame a Colleen Ford 301-378-9140, número de fax: 301-378-9127

PART I - HEALTH ASSESSMENT
To be completed by parent or guardian

Child's Name: ______________________ Last / First / Middle **Birth date:** ________ Mo / Day / Yr **Sex** M☐ F☐

Address: ______________________ Number / Street / Apt# / City / State / Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Medical Care Provider	Health Care Specialist	Dental Care Provider	Health Insurance	Last Time Child Seen for
Name:	Name:	Name:	☐ Yes ☐ No	Physical Exam:
Address:	Address:	Address:	Child Care Scholarship	Dental Care:
Phone:	Phone:	Phone:	☐ Yes ☐ No	Specialist:

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies	☐	☐	
Asthma or Breathing	☐	☐	
ADHD	☐	☐	
Autism Spectrum Disorder	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Communication	☐	☐	
Developmental Delay	☐	☐	
Diabetes Mellitus	☐	☐	
Ears or Deafness	☐	☐	
Eyes	☐	☐	
Feeding/Special Dietary Needs	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where, Why)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening/Anaphylactic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Mobility-Assistive Devices if any	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sensory Impairment	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Vision	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form.

Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy /Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.)

☐ No ☐ Yes, If yes, attach the appropriate OCC 1216 form and Individualized Treatment Plan

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

____

Printed Name and Signature of Parent/Guardian   Date

CHILD HEALTH RECORD: SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

Child's Name: Sex: DOB:

Address: Phone:

1. Relevant Information (from Health History, Parent/Teacher Observations):

2. Screening Tests: Starred items are required by our Child Care program/Head Start and recommended by the American Academy of Pediatrics for Children 3-5 years. Enter dates and results if done previously.

TEST	DATE	RESULTS	TEST	DATE	RESULTS
A. Present Age: ★		____Yrs. ____Mos.	G. Other Test(if indicated)		
B. Height(no shoes to nearest 1/8 in.): ★			1. Lead: ★		
C. Weight (light clothing to nearest 1/4 lb.): ★			2. TB Questionnaire ★		
			3. Sickle Cell:		
D. Blood Pressure: ★			4. Ova & Parasites:		
			5. Urinalysis:		
E. Hematocrit or Hemoglobin: ★			6. Other:		
F. Hearing: (Type of Test) ★			H. Vision: (Type of Test) ★		
Results, R/L:			Acuity, R/L:		
Rescreening:			Rescreening:		
Comments:			Strabismus:		
			Comments:		

3. Physical Examination/Assessment:

	Normal for age	Abnor-mal	Not eval
A. General Appearance			
B. Posture, Gait			
C. Speech			
D. Head			
E. Skin			
F. Eyes:			
(1) External Aspects			
(2) Optic Fundiscopic			
(3) Cover Test			
G. Ears:			
(1) External & Canals			
(2) Tympanic Membranes			
H. Nose, Mouth, Pharynx			
I. Teeth			
J. Heart			
K. Lungs			
L. Abdomen (include hernia)			
M. Genitalia			
N. Bones, Joints, Muscles			
O. Neurological/Social:			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication Skills			
(4) Cognitive			
(5) Self Help Skills			
(6) Social Skills			
P. Glands (Lymphatic/Thyroid)			
Q. Muscular Coordination			
R. Ant. Guidance Discussed ★			

ANTICIPATORY GUIDANCE

★ 3 Years Old

Social:	Needs Peers:	
	Caution w/ strangers/animals	
Parenting:	Time outs:	
	Avoid spanking:	
	Praise child:	
Nutrition:	Variety of Nutritious foods:	
	May be picky:	
	Fluoride if well water:	
Health:	Dental care:	
	Physical activity:	
	Begin sex education: (private parts)	
Injury Prevention:	Car seat:	
	Rear riding seat:	
	Bicycle helmets:	
	Smoke detector/plan:	
	Hot water temp:	
	Firearms:	
	Water safety: (tub/pool)	
Play:	Read to child:	
	Screen TV shows:	

★ 4/5 Years Old

Social:	School readiness:	
	Enrolled in PK/K:	
	Teach address/Phone#:	
Parenting:	Allow separation:	
	Awareness of Learning disabilities:	
Nutrition:	Choose nutritional food:	
	Help choose foods for meals;	
Health:	Dental care:	
	Bedwetting:	
	Nightmares:	
	Normal sexual curiosity:	
	Physical activity:	
Injury Prevention:	Car seat:	
	Rear riding seat:	
	Bicycle helmets:	
	Smoke detector/plan:	
	Matches:	
	Poison control #:	
	Fall prevention (playground):	
	Water safety:	
Play:	Small chores:	
	Monitor TV use:	
	Creative, active, & group play:	

S. General Statement on Child's Physical Status:

Health Care Provider's Signature: ____________________ Date: ________

4. Findings, Treatments, and Recommendations:

Abnormal Findings/Diagnosis	Treatment Plan	Recommended Follow-up or Results (initial when complete)	Date
A.			
B.			
C.			

MARYLAND DEPARTMENT OF HEALTH IMMUNIZATION CERTIFICATE

CHILD'S NAME ____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _______/_______/_______

COUNTY ____________________ SCHOOL ______________________________ GRADE ______

PARENT OR GUARDIAN NAME ______________________________ PHONE NO. ____________________

GUARDIAN ADDRESS ______________________________ CITY ____________________ ZIP ________

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	Varicella Disease Mo / Yr	COVID-19 Mo/Day/Yr
1													
2													
3									Td Mo/Day/Yr	Tdap Mo/Day/Yr	MenB Mo/Day/Yr	Other Mo/Day/Yr	
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. ____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. ____
Signature Title Date

3. ____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM VACCINATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY VACCINATION(S) THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:

Please check the appropriate box to describe the medical contraindication.

This is a: ☐ Permanent condition OR ☐ Temporary condition until _______/_______/_______
Date

The above child has a valid medical contraindication to being vaccinated at this time. Please indicate which vaccine(s) and the reason for the contraindication, ____

Signed: ______________________________ Date ____________________
Medical Provider / LHD Official

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any vaccine(s) being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: ______________________________ Date: ____________________

How To Use This Form

The medical provider that gave the vaccinations may record the dates (using month/day/year) directly on this form (check marks are not acceptable) and certify them by signing the signature section. Combination vaccines should be listed individually, by each component of the vaccine. A different medical provider, local health department official, school official, or child care provider may transcribe onto this form and certify vaccination dates from any other record which has the authentication of a medical provider, health department, school, or child care service.

Only a medical provider, local health department official, school official, or child care provider may sign 'Record of Immunization' section of this form. This form may not be altered, changed, or modified in any way.

Notes:

1. When immunization records have been lost or destroyed, vaccination dates may be reconstructed for all vaccines except **varicella, measles, mumps, or rubella.**

2. Reconstructed dates for all vaccines must be reviewed and approved by a medical provider or local health department no later than 20 calendar days following the date the student was temporarily admitted or retained.

3. Blood test results are NOT acceptable evidence of immunity against diphtheria, tetanus, or pertussis (DTP/DTaP/Tdap/DT/Td).

4. Blood test verification of immunity is acceptable in lieu of polio, measles, mumps, rubella, hepatitis B, or varicella vaccination dates, but **revaccination may be more expedient**.

5. History of disease is NOT acceptable in lieu of any of the required immunizations, except varicella.

Immunization Requirements

The following excerpt from the MDH Code of Maryland Regulations (COMAR) 10.06.04.03 applies to schools:

"A preschool or school principal or other person in charge of a preschool or school, public or private, may not knowingly admit a student to or retain a student in a:
(1) Preschool program unless the student's parent or guardian has furnished evidence of age appropriate immunity against Haemophilus influenzae, type b, and pneumococcal disease;
(2) Preschool program or kindergarten through the second grade of school unless the student's parent or guardian has furnished evidence of age-appropriate immunity against pertussis; and
(3) Preschool program or kindergarten through the 12th grade unless the student's parent or guardian has furnished evidence of age-appropriate immunity against: (a) Tetanus; (b) Diphtheria; (c) Poliomyelitis; (d) Measles (rubeola); (e) Mumps; (f) Rubella; (g) Hepatitis B; (h) Varicella; (i) Meningitis; and (j) Tetanus-diphtheria-acellular pertussis acquired through a Tetanus-diphtheria-acellular pertussis (Tdap) vaccine."

Please refer to the "**Minimum Vaccine Requirements for Children Enrolled in Pre-school Programs and in Schools**" to determine age-appropriate immunity for preschool through grade 12 enrollees. The minimum vaccine requirements and MDH COMAR 10.06.04.03 are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

Age-appropriate immunization requirements for licensed childcare centers and family day care homes are based on the Department of Human Resources COMAR 13A.15.03.02 and COMAR 13A.16.03.04 G & H and the "**Age-Appropriate Immunizations Requirements for Children Enrolled in Child Care Programs**" guideline chart are available at www.health.maryland.gov. (Choose Immunization in the A-Z Index)

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME ______________________ / ______________ / ______________
LAST FIRST MIDDLE

CHILD'S ADDRESS ______________________ / ______________ / ______________ / ______________
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ☐Male ☐Female BIRTHDATE ____/____/____ PHONE ______________

PARENT OR GUARDIAN ______________________ / ______________ / ______________
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ☐ YES ☐ NO
Has this child ever lived in one of the areas listed on the back of this form? ☐ YES ☐ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ☐ YES ☐ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): ______________ **Signature:** ______________ **Date:** ______________

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ☐Health Care Provider/Designee OR ☐School Health Professional/Designee

Provider Name: ______________ Signature: ______________

Date: ______________ Phone: ______________

Office Address: ______________

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): ______________ Signature: ______________ Date: ______________

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ☐ YES ☐ NO

Provider Name: ______________ Signature: ______________

Date: ______________ Phone: ______________

Office Address: ______________

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.

DHMH FORM 4620 REVISED 5/2016 REPLACES ALL PREVIOUS VERSIONS

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: (every well child visit from 6 months up to 6 years)	Date	Date	Date	Date	Date	Date	Date
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

★ Tuberculosis Risk Assessment: (Starting at 1 month of age and annually thereafter)	Date	Date	Date	Date	Date	Date	Date
1. Has your child been exposed to anyone with a case of TB **or** a positive tuberculin skin test?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Anemia Screening (Starting at 11 years of age and annually thereafter)	Date	Date	Date	Date	Date	Date	Date
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: ______________________ **Birth Date:** ____________

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 2016

Health Care Provider's Signature: ____________________

Health Care Provider's Signature: ____________________

Programa para Niños Saludables de Maryland (Maryland Healthy Kids Program)
Cuestionario de Detección Temprana

Evaluación sobre riesgo de Plomo (envenenamiento con Plomo): *(En cada visita desde los 6 meses hasta los 6 años)*	fecha	fecha	fecha	fecha	fecha	fecha	fecha
1. ¿Su niño/a ha vivido o se ha quedado en alguna casa o apartamento que se haya construido antes del 1978? (incluyendo el centro de cuido, hogar prescolar, casa de la niñera o algún pariente)	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿Hay alguien en su casa que haya sido tratado por envenenamiento con Plomo?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. ¿Ha habido renovaciones recientes o se ha pelado la pintura en alguna casa que su hijo/a visite a menudo?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿Su niño/a lame, come o mastica cosas que no sean comida? (pedacitos de pintura, tierra, rejas, barrotes, columnas, muebles, juguetes viejos, etc.)	S / N	S / N	S / N	S / N	S / N	S / N	S / N
5. ¿Hay algún familiar que esté trabajando en una ocupación o pasatiempo donde sea posible que se haya expuesto al plomo? (mecánico de autos, ceramista, pintor comercial, etc.)	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Evaluación sobre riesgo de Tuberculosis: *(Empezando en un año y anualmente a partir de esa fecha)*	fecha	fecha	fecha	fecha	fecha	fecha	fecha
1. ¿ Ha sido su hijo/hija expuesto a una persona con un caso de Tuberculosis o ha alguien con una prueba cutanea de tuberculina positiva?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿ Fue su hijo/hija nacido, o algun miembro en su hogar, en un pais de alto-riesgo (paises que no sean los Estados Unidos, Canada, Australia, Nueva Zelanda, o paises de Europa occidentales o del norte)?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. ¿ Ha viajado su hijo/hija (tuvo contacto con la poblacion residente) de un pais de alto-riesgo por mas de una semana?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿Tiene su niño/a contacto diario con adultos que esten en alto riesgo de tener o contraer tuberculosis (ejemplo: personas con la infección del VIH, vagabundas (homeless), encarceladas, y/o que usen drogas)?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
5. ¿Tiene su niño la infección del VIH (HIV)? (una respuesta afirmativa a cualquier pregunta indica un posible riesgo)	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Detección de anemia *(A partir de 11 años de edad y anualmente en lo sucesivo)*							
1. ¿Incluye su dieta alimentos abundantes en hierro como carne, huevos, cereales fortificados con hierro o frijoles?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
2. ¿Ha sido diagnosticado alguna vez con anemia por deficiencia de hierro?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
3. (sólo mujeres) ¿Tiene sangrado menstrual excesivo u otras pérdidas de sangre?	S / N	S / N	S / N	S / N	S / N	S / N	S / N
4. ¿ (sólo mujeres) Dura su periodo menstrual más de 5 días?	S / N	S / N	S / N	S / N	S / N	S / N	S / N

Nombre del Paciente:____________________ Fecha de Nacimiento:__________

NATIONAL CENTER ON
Early Childhood Health and Wellness

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 of service

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Formulario de Salud Bucal — Niños

Información sobre el paciente

Nombre del niño | Fecha de nacimiento | Nombre del padre/la madre/el tutor | Número de teléfono

Dirección | Ciudad | Estado | Código postal

Este consultorio es el lugar de atención habitual del niño: ☐ Sí ☐ No

Estado de salud bucal actual

¿Tiene el niño dientes con caries no tratadas? ☐ Sí (con caries) ☐ No (sin caries)

¿Tiene el niño algún diente que haya sido tratado previamente por caries, incluidos empastes, coronas o extracciones? ○ Sí ○ No

¿Se necesita algún tratamiento? ☐ Sí, con urgencia. ☐ Sí, sin urgencia. ☐ No se necesita ningún tramiento

Servicios de atención médica bucal prestados durante la visita

Servicios de diagnóstico/preventivos

Examinación: ○ Sí ○ No

Rayos X: ○ Sí ○ No

Evaluación de riesgo: ○ Sí ○ No

Limpieza: ○ Sí ○ No

Fluoride varnish: ○ Sí ○ No

Selladores dentales: ○ Sí ○ No

Asesoramiento/Orientación anticipada

○ Sí ○ No

Derivación a atención especializada

○ Sí ○ No

____

(Indicar especialista)

Atención de emergencia/restauración

Empastes: ○ Sí ○ No

Coronas: ○ Sí ○ No

Extracciones: ○ Sí ○ No

Atención de emergencia: ○ Sí ○ No

Otro: _______________

(Indicar)

Futuros servicios de atención médica bucal

Todos los tratamientos completados: ○ Sí ○ No

Próxima fecha de visita: ______ / ______ (mes/año)

¿Se necesitan más citas para el tratamiento? ○ Sí ○ No

Si la respuesta es "sí": Cantidad aproximada de citas necesarias: ____

Próxima cita: Fecha: ________ Hora: ________

Información adicional para los padres, el personal de Head Start y los profesionales médicos

Información de contacto y firma del profesional de salud bucal

Nombre del profesional (*en imprenta*) | Número de teléfono | Número de fax

Nombre del consultorio | Dirección

Firma del profesional | Fecha del servicio

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ADMINISTRATION FOR CHILDREN & FAMILIES

NATIONAL CENTER ON Early Childhood Health and Wellness