Prairie Five Head Start Well Child Exam

Child's Name _____ Date of Birth _____ Sex _____

Parent Name _____ **Date of Exam** _____

Name of Clinic _____ Clinic Phone # _____

This Child's Well Child Exam should be billed to:

☐ *Private Insurance* ☐ *Medical Assistance* ☐ *Prairie Five CAC (***with PRIOR APPROVAL***)*

Mandatory Screenings-MUST BE COMPLETED for Head Start enrollment

Height: _____inches ***Weight***: _____ lbs ***BMI***: _____% ***Blood Pressure***: _____/_____

HGB #: _____ Date: _____ ***Immunizations current?*** ☐Yes ☐No

Lead #: _____ Date: _____ (Attach copy of immunization record)

Area	N/AB	Comments	Area	N/AB	Comments
1. Head			10. Spine		
2. Face			11. Cardiovascular		
3. Neck			12. Abdomen		
4. Eyes			13. Genitalia		
5. Ears			14. Extremities		
6. Nose			15. Joints		
7. Mouth			16. Muscle Tone		
8. Throat			17. Skin		
9. Chest			18. Neurological		

1. Does child have any allergies? (Food, drug, insect, other) ☐ No ☐ Yes (**If yes, allergy documentation on back MUST be completed**)
2. Is child developing appropriately for age? ☐ No ☐ Yes If no, what modifications are needed _____
_____
3. Is a special diet necessary? ☐ No ☐ Yes Identify restrictions: _____
4. List medications (**Complete permission on back for classroom administration**) _____
5. Is there a condition which may result in an emergency? ☐ No ☐ Yes Specify: _____
6. Indicate any notable health problems: _____
7. Indicate any restrictions or recommendations:_____
8. Referrals: _____
9. Was fluoride varnish applied? ☐ No ☐ Yes

Printed Health Provider Name: _____

Provider Signature: _____ Date: _____

Please mail or fax the completed form to:

Prairie Five Head Start
P.O Box 166
Madison, MN 56256
Phone: 320-598-3118
Fax: 844-273-2299

45 CFR 1302.42 **HC: _____ CP: _____ HS Center: _____ Date entered into ChildPlus: _____**

Individual Child Care Program Plan for Allergies

(Completed by Health Care Provider)

Child's Name:_____ **D.O.B:**_____

Descr. of Allergy:_____

Severity: ☐Intolerance only ☐Mild ☐Moderate ☐Severe

What can trigger a reaction: ☐Eating it ☐Touching or eating it ☐Smelling, touching or eating it ☐Other, please list: _____

Avoidance Techniques: _____

Symptoms:_____

Procedures for Responding to an Allergic Reaction:

Symptoms that would indicate the need to implement the emergency plan:_____

If the child develops the symptoms listed above, classroom staff should:

☐Administer prescribed Epi-Pen immediately

☐Call 911

☐Administer other prescribed medication, please list medication:_____

☐Call parent

☐Call child's physician

☐Stay with child at all times ☐other, please list:_____

Provider Information:

Clinic Name: _____ **Clinic Address**: _____

Provider Name: _____**Provider Phone:** _____

**If medication needs to be administered, physician must fill in form below.*

Provider Signature: _____ **Date:**_____

Permission for Head Start Staff to Administer Prescription or Non-Prescription Medication in the Classroom

(Completed by Health Care Provider **WITH** Parent Signature)

Child's Name:_____**D.O.B:**_____

I have prescribed the following medication for this child and request that dose required during center hours be administered by Head Start staff

Name of medication:_____

Condition for which prescribed:_____

Possible side effects:_____

Instructions for use: _____

Dosage:_____ Frequency: _____

Duration: _____ Date prescribed: _____

Training required for administration: ☐Yes ☐No Storing instructions: _____

Provider Signature: _____ **Date:**_____

I request the above medication to be given to my child as prescribed

Parent Signature: _____ **Date:**_____