Program Year 2022-2023
Section 1
Enrollment/Transportation Checklist

Child's Name:
(Last, First) _____
Date of Birth: _____
Parent's Name _____

❑	1520 ChildPlus	Contact Information (Emergency Form) ChildPlus Form *Update as needed. Parent/Guardian will sign and date printed copy. Original signed copy is filed. Copy 1 will be given to classroom teacher, copy 2 bus driver (if applicable).*
❑	Restraining Order	Restraining Order (if applicable) *Upload to ChildPlus under the enrollment tab and file in Section 1 of child binder.* *Notify ERSEA Manager, to ensure adult listed on restraining order is no longer listed on emergency form (contact Information)*
❑	E-109 ChildPlus	Document of Receipt *(Child Plus form with digital signatures)*
❑	Lic. 995 & Lic. 613A	Lic. 995 Notification of Parents' Rights Lic. 613A Personal Rights *Original signed copy is filed.*
❑	E-142 ChildPlus	Individualized Hours of Care (Full-Day & FCCP only) *(Child Plus form with digital signatures).*
❑	TR-811	Field Trip Permission Slips (if applicable)
❑	E-300 ChildPlus	Child File Transfer Acknowledgment (if applicable) *(Child Plus form with digital signatures)*

Section 2
EHS-Health and Nutrition
File Checklist

❑	H-208 EHS Child Plus	Parent Consent for Screening –print out
❑	H-201 EHS Child Plus	Health History - print out
❑	H-201B EHS	Well Baby Physical Examination (2,4,6,9,12,15,18,24,30, AND 36 MONTH)
❑		Well baby Physical Follow-up (if applicable)
❑	H-212	Supplemental Health Services
❑	H 201C CB/HB	Infant Needs and Service Plan
❑	H-204	Dental Examination
❑	Child Plus 3410	Growth Chart Report/ Body Mass Index BMI Report
❑	N-615 EHS	Nutrition Assessment and Infant Feeding Plan
❑	Child Plus 3390	Shot Records/ CP Report-3390 California School Immunization Record
❑	H-218	Temporary Health Exclusion Letter (if applicable)
❑	H-217	Reminder Letter (if applicable)
❑	H-225	Child Incident Report (if applicable)
❑	H-243	Medication Administration Authorization (if applicable)
❑	H-244	Medication Administration Log (if applicable)
❑	H-245	Medication Intake Form (if applicable)
❑	H-256	Individual Health Plan for other and multiple medical conditions (if applicable)
❑	H-256 (A)	Individual Health Plan for Asthma (if applicable)
❑	H-257	Re- Certification of Individual Health plan (if applicable)
❑	N-614	Medical Statement to Request Special Meals and/or Accommodations (if applicable)
❑		CACFP Declining Participation in Food Program
❑	AD-04	Parent Consent for Release of Information (if applicable)

WELL BABY PHYSICAL

This exam is for Month: (please circle) 1 2 4 6 9 12 15 18 24 30

Due date:

Child's Name: **Birth Date:** **Sex:** ❑ **Male** ❑ **Female**

Early Head Start Site:

Exam Date: _____ **Practice/Clinic Stamp:** _____

Provider (Please Print): _____ **Address:** _____

Signature: _____ **Phone Number:** _____

Height/Length **Inches** | **Weight:** **lbs** **oz** **Weight/length or BMI:** _____ **Head Circumference:** _____

Nutritional Assessment: ❑ Pass ❑ Fail
Referrals made:

Feeding recommendations ❑ puree ❑ soft ❑ table food (under 12 m)

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin			Mouth			Abdomen		
Head			Teeth			Genitalia		
Neck			Throat			Developmental		
Lymph Nodes			Chest			Extremities		
Eyes-Strabismus			Lungs			Motor Ability		
Ears			Heart			Speech		
Nose			Back			Behavioral		

Hearing (clinical observation) Grossly Within Normal Limits:
☐ Yes ☐ No

Vision (Clinical observation) Grossly Within Normal Limits:
☐ Yes ☐ No

Children with Publicly Funded Insurance require Lead blood test at both 12 and 24 months, OR once between 24-72 months

LABORATORY

Hgb/Hct results	**Age**	**Date**
	12 mo	
Hematocrit/Hemoglobin Risk Assessment	**At Risk**	**Not at Risk**
Hematocrit/Hemoglobin Test (if applicable)	**Date**	**Results**
Lead Results	**Age**	**Date**
	12 mo.	
	24 mo	

COMPLETE RISK ASSESSMENTS

TB Risk Assessment	☐ RISK	☐ NO RISK
LEAD Assessment	☐ RISK	☐ NO RISK
TOBACCO Assessment	☐ RISK	☐ NO RISK

DENTAL SCREENING

☐ Normal ☐ Abnormal

Dental exam recommended at this time

☐ yes ☐ no

TB MANTOUX TEST & RESULT

Date Given:	Date Read:
□ Positive	□ Negative

Chest Xray

□ Positive	□ Negative
Rx Date:	

ASTHMA: ❑ **Yes** ❑ **No**

Allergies:

Please indicate the immunizations received:

☐ Polio	☐ DTaP	☐ Hepatitis B	☐ MMR	☐ Rotovirus	☐ Varicella
☐ Pneum	☐ Hept. A	☐ Influenza	☐ Hib Booster		

Comments / Follow up needed / Referrals:

Received at EHS by: _____ Date:_____ Data entry by:_____ Date:_____

STAMP HERE:

Dear CHDP Medical Provider,

MAAC Child Developmental Program is federally funded to provide Early Head Start and Head Start services to income and special need qualified children and families. Head Start Performance Standards require each child to be up-to-date on the EPSDT schedule.

Please take the time to perform **ALL** of the required screenings indicated on the "Well Baby Exam" form. Head Start requires proof of a blood lead level test at 12 and at 24 months of age as indicated on the EPSDT. In the event that the child was not tested at 24 months, a blood lead test is required during this visit.

Your role is very important in helping us to ensure that our children and families receive quality care, education, and services.

Should you have any questions, please feel free to contact me at (760) 471-4210, Ext. 2265.

Sincerely,

Rebecca Kirkpatrick

Rebecca Kirkpatrick
Health and Nutrition Manager

EHS H-204

DENTAL EXAMINATION FORM

Child's Name:
(Last, First) _____
Date of Birth: _____
Parent's Name

EARLY HEAD START CENTER/FCCP: _____

To be completed by Dental Professional

Dental Examination

Date of Examination _____

Examination:	❒ Yes	❒ No	Cleaning:	❒ Yes	❒ No
X-rays:	❒ Yes	❒ No	Flouride varnish:	❒ Yes	❒ No
Oral Hygiene Instruction :	❒ Yes	❒ No	Dental sealants:	❒ Yes	❒ No

Dental Treatment Needed

Restorative /Emergency Care

Filling:	❒ Yes	❒ No	Referral Speciality Care	❒ Yes	❒ No
Crowns:	❒ Yes	❒ No	Date Treatment was received: _____		
Extractions:	❒ Yes	❒ No			
Emergency Care:	❒ Yes	❒ No			

Future Dental Treatment Needed

More appointments needed for treatment? ❒ Yes ❒No

Next appointment: Date:_____ Time: _____

Future Dental Examination Needed

Next recall date: _____ / _____ (Month/Year)

Dental Provider's Contact Information and Signature/Official Stamped Signature

Provider's Signature : _____ **Date:** _____

Official Dental Provider's Stamp

Address: _____ **Phone Number:** _____ **Fax:** _____

_____

_____

For MAAC Staff Use Only
Date Received by MAAC staff
_____/_____/_____

Section 3
Family and Community Engagement
File Checklist

❑	ChildPlus	Family Partnership Agreement Process (See ChildPlus)
❑	CCR	Strengths, Needs, Interest Parent Survey (SNIP)
❑		