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
HS-Health and Nutrition
File Checklist

❑	H-208 Child Plus	Parent Consent for Screening – (print out)
❑	H-201HS Child Plus	Health History – (print out)
❑	H-201B	Physical Examination
❑		Physical Follow-up (if applicable)
❑	H-212	Supplemental Health Services
❑	H-204	Dental Examination
❑	N-615	Nutrition Assessment
❑	IZ record	Shot Records
❑	CP-3390 Child Plus	California Blue School Immunization Record
❑	CP-3410 Child Plus	Growth Chart Report/ Body Mass Index BMI Report
❑	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-246	Over-the-Counter Administration 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 (if applicable)
❑	AD-04	Parent Consent for Release of Information (if applicable)

HEAD START PHYSICAL EXAM

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 "Physical Examination" 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. Children in Early Head Start children must have the 30 month well baby check.

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

HEAD START PHYSICAL EXAM

Child's Name: ______________________ **Birth Date:** ______________

Head Start Site: **Sex:** ☐ **Male** ☐ **Female**

Exam Date: ______________ **Clinic Name:** ______________

Doctor's Name: ______________ **Address:** ______________

Doctor Signature: ______________ **Phone Number:** ______________

Height: (%)	**Weight:** (%)	**Blood Pressure:**

LABORATORY

Children participating in publically funded programs require a Lead blood test at 24 months or older.

Lead Blood Test (At 24 months & up)	Date of test:	**Must have result** Value:	IMMUNIZATION UP TO DATE FOR AGE:	❑ Yes	❑ No
SCREENING ASSESSMENTS ARE REQUIRED ANNUALLY			**Allergies(list):**		
Hematocrit/Hemoglobin Risk Assessment	Date:	At Risk: ❑ Yes ❑ No			
Hematocrit/Hemoglobin Test (if applicable)	Date:	Results:			

Is child at Risk for TB?: ☐ Yes ❑ No	**Tuberculin Skin Test:**		Results:	Chest X-ray Date:	Results:	Rx Date:
If Yes, will child require a skin test? →	Date of Test:	Date Read:	☐ Positive ☐ Negative		☐ Positive ☐ Negative	

IDENTIFY ANY SPECIAL NEEDS/ADAPTIVE EQUIPMENT OR CHRONIC CONDITIONS THAT REQUIRE INDIVIDUAL HEALTH ACCOMODATIONS:

VISION	**Date:**
Acuity-Right Eye:	/
Acuity-Left Eye:	/
Strabismus:	

HEARING	**Date:**		
Frequency	**1000**	**2000**	**4000**
Right Ear	dB	dB	dB
Left Ear	dB	dB	dB

FINDINGS, TREATMENTS & RECOMMENDED FOLLOW UP:

LIST MEDICATION AND DOSAGE:

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:** ____________

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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)
❑		