



GREEN HILLS HEAD START MEDICAL EXAMINATION 2011-2012



READ BEFORE BILLING

Head Start will pay ONLY if the child is NOT ELIGIBLE for insurance or Medicaid. A current denial of Medicaid from FSD must be on file before Head Start funds can be authorized for payment. Payment fees for services are recommended by the Health Advisory Board. **Please contact Head Start for prior approval. If approved, Head Start will pay up to \$45 for physicals, \$5 for HCT's, and \$10 for lead screenings.**

Bill Medicaid? NO YES Medicaid Number: _____ Payment Authorized by: _____

Mail to: Green Hills Head Start, 205 West 18th Street, Trenton, MO 64683 (660)359-2214 Fax: (660)359-5787

CHILD INFORMATION

Child's Name:	Parent's Name:
Birthdate:	Address:
Head Start Location:	Phone:

IMMUNIZATIONS GIVEN (give date)

DTP/DT:	Polio:	Hib:	MMR:	Hep A:	Hep B:	Varicella:	PCV:	Other:
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PHYSICAL EXAMINATION / ASSESSMENT

	Normal	Abnormal	Not Evaluated	Comments
General Appearance				
Posture, Gait				
Speech				
Head				
Skin				
Eyes: External Aspects				
Optical Fundiscopic				
Cover Test				
Ears: External/Canals				
Tympanic Membrane				
Nose/Mouth/Pharynx				
Teeth				
Heart				
Lungs				
Abdomen				
Genitalia				
Bones/Joints/Muscles				
Neurological/Social				
Gross Motor				
Fine Motor				
Communicative Skills				
Cognitive				
Self-Help Skills				
Social Skills				
Glands/Lymphatic/Thyroid				
Muscular				

REQUIRED INFORMATION

Hematocrit/Hemoglobin:	
Blood Lead Testing:	
Blood Pressure:	
Height:	Weight:
Does this child have asthma? No *Yes <i>If yes, will the child need medication during school hours?</i> No *Yes	
Does this child have a seizure disorder? No *Yes <i>If yes, will the child need medication during school hours?</i> No *Yes <small>*If the child has asthma or seizures please fill out the back of this form.*</small>	
Does this child need an iron supplement? <i>Include prescription</i> No Yes	
Does this child require any specialized care? No Yes	
Abnormal Findings/Diagnosis & Treatment Plan or Results:	

PLEASE SIGN

I have examined the above named child and verify that this child's medical history and current state of health IS IS NOT satisfactory for participation in a day care program.

Doctor's Signature: _____ Date: _____

CFNP's Signature: _____ Supervising Physician's Name: _____ Date: _____



Missouri Department of Health and Senior Services
Section for Child Care Regulation
INDIVIDUAL PLAN FOR SPECIALIZED CARE

IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

AREA OF CONCERN

ADAPTIVE EQUIPMENT OR SUPPLIES NEEDED AT DAY CARE

MEDICATION/TREATMENT CHILD IS TO RECEIVE AT FACILITY DURING CHILD CARE HOURS

If the child is to receive treatments during his/her scheduled hours of care, how and by whom is this treatment to be administered?

SYMPTOMS/INDICATORS/POSSIBLE PROBLEMS RELATING TO CHILD'S CONDITION/TREATMENT HEALTH PROBLEMS THAN CAN RESULT IN AN EMERGENCY

PHYSICIAN/SPECIALIST SIGNATURE

DATE

X