WELCOME to the El Dorado County Office of Education, Child Development Programs. In order for us to efficiently process your application for enrollment in the Child Development Programs, please complete the enclosed application packet and attach the following documentation when submitting your application. All documentation is required to complete an application and be considered for enrollment:

- Birth certificate
- Birth certificates for other children in the family
- Current immunizations
- Family or child’s medical card
- Income verification (paycheck stub, etc.) for one full month, not required for fee paying families
- Single parent status verification
- IEP/IFSP (if applicable)

All children accepted into program will require proof of a current physical exam or have one completed within 30 days of starting program.

If you are applying for a Head Start or State Preschool classroom, please indicate your top three choices below:

<table>
<thead>
<tr>
<th>CHILD DEVELOPMENT PROGRAM HEAD START and STATE PRESCHOOL SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3 and 4 year old children)</td>
</tr>
<tr>
<td>_____ Al Tahoe Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Blue Oak State Preschool</td>
</tr>
<tr>
<td>_____ Brooks State Preschool</td>
</tr>
<tr>
<td>_____ Buckeye Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Camino Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Camerado Springs Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Charles Brown Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Georgetown Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Gold Oak Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Green Valley State Preschool</td>
</tr>
<tr>
<td>_____ Home Based Head Start</td>
</tr>
<tr>
<td>_____ Jackson State Preschool</td>
</tr>
<tr>
<td>_____ Ken Lowry Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Pinewood Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Placerville Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Rescue Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Sutter’s Mill State Preschool</td>
</tr>
<tr>
<td>_____ Tahoe Head Start/State Preschool</td>
</tr>
<tr>
<td>_____ Valley View Montessori State Preschool</td>
</tr>
</tbody>
</table>

How did you hear about our program?
- Friend/Family
- EDCOE Website
- Newspaper/Advertisement
- Facebook
- Other

FOR OFFICE USE ONLY

Date Application Received _______________ Staff Initials ________

- Application is COMPLETE. More information regarding enrollment to follow.
- Application is NOT COMPLETE. Please submit the missing/incomplete items highlighted above. See notes below.
El Dorado County Office of Education Child Development Programs
6767 Green Valley Road, Placerville, CA 95667 ~ (530) 295-2270 / 295-2276 FAX (530) 626-9511
HEAD START / EARLY HEAD START / STATE PRESCHOOL

CHILD DEVELOPMENT PROGRAMS

2018/2019 APPLICATION FOR PROGRAM SERVICES

Form: M-A-116\1819

Child's Legal Name

Last: ____________________________ First: ____________________________

Race:  □ American Indian/Alaskan Native □ Asian □ Black/African-American
□ Hawaiian/Pacific Islander □ White □ Multi-Racial
□ Other: _________________________ Hispanic: ____________ Primary Language at home: ____________ Parental Status

□ Yes □ No □ English □ Yes □ No □ Spanish □ Other: ____________________________

□ One parent □ Foster □ Two parent □ Guardian

Has your child previously been enrolled in a Child Development Program? □ Yes □ No
Does your child have a special need, disability or chronic health issue? □ Yes □ No

Requested Site(s): 1) ____________________________ 2) ____________________________
3) ____________________________ Fee Base Preschool days requested: M T W TH F

Primary Adult

Last: ____________________________ First: ____________________________

Birthdate: ____________________________ Female/Male: ____________________________ Social Security Number: ____________________________

Relationship to Child: □ Biological/Adopted/Step □ Foster/Guardian □ Aunts/Uncles
□ Grandparent □ Other

Check all that Apply: □ Lives with Family □ Provides Financial Support
□ Teen Parent □ Educational Rights:

□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No

Physical Custody: □ Yes □ No □ Yes □ No □ Yes □ No

Highest Grade Completed: □ Associates □ Bachelor's □ Master's
□ College □ Training □ School Training □ GED

□ Yes □ No □ Yes □ No □ Yes □ No

TANF / Supplemental Social Security Income: □ Yes □ No □ Yes □ No □ Yes □ No

Employment/Income Status

□ Full-time employment (over 35 hrs. week) □ Part-time employment (under 35 hrs. week) □ Unemployed □ Retired or Disabled

□ Full-time □ Part-time & Training □ Training or School □ No

□ Training □ Part-time Training □ No □ Yes □ No

□ Yes □ No □ Yes □ No □ Yes □ No

Race: □ American Indian/Alaskan Native □ Asian □ Black/African-American
□ Hawaiian/Pacific Islander □ White □ Bi-Racial/Multi-Racial
□ Other: ____________________________

Food Stamps? □ Yes □ No □ Yes □ No FS Case #: ____________________________

WIC? □ Yes □ No □ Yes □ No

Cell Phone Number: ____________________________ Other Phone Number: ____________________________

( ) □ Home □ Work □ Cell □ Msg.

□ Yes □ No □ Yes □ No □ Yes □ No

Secondary Adult

Last: ____________________________ First: ____________________________

Birthdate: ____________________________ Female/Male: ____________________________ Social Security Number: ____________________________

Relationship to Child: □ Biological/Adopted/Step □ Foster/Guardian □ Aunts/Uncles
□ Grandparent □ Other

Check all that Apply: □ Lives with Family □ Provides Financial Support
□ Teen Parent □ Educational Rights:

□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No

Physical Custody: □ Yes □ No □ Yes □ No □ Yes □ No

Highest Grade Completed: □ Associates □ Bachelor's □ Master's
□ College □ Training □ School Training □ GED

□ Yes □ No □ Yes □ No □ Yes □ No

TANF / Supplemental Social Security Income: □ Yes □ No □ Yes □ No □ Yes □ No

Employment/Income Status

□ Full-time employment (over 35 hrs. week) □ Part-time employment (under 35 hrs. week) □ Unemployed □ Retired or Disabled

□ Full-time □ Part-time & Training □ Training or School □ No

□ Training □ Part-time Training □ No □ Yes □ No

□ Yes □ No □ Yes □ No □ Yes □ No

Race: □ American Indian/Alaskan Native □ Asian □ Black/African-American
□ Hawaiian/Pacific Islander □ White □ Bi-Racial/Multi-Racial
□ Other: ____________________________

Food Stamps? □ Yes □ No □ Yes □ No FS Case #: ____________________________

WIC? □ Yes □ No □ Yes □ No

Cell Phone Number: ____________________________ Other Phone Number: ____________________________

( ) □ Home □ Work □ Cell □ Msg.

□ Yes □ No □ Yes □ No □ Yes □ No

Family Information

Temporary Housing? □ Yes □ No

Physical Street Address: ____________________________ City: ____________________________ State: ____________ Zip: ____________

Contact E-Mail Address: ____________________________

Mailing Address (if different): ____________________________ City: ____________________________ State: ____________ Zip: ____________

Contact E-Mail Address (if available)

Please list other children or family members living in your household that you are financially supporting:

Name: ____________________________ Race: ____________ DOB: ____________________________ Gender: ____________

Name: ____________________________ Race: ____________ DOB: ____________________________ Gender: ____________

Name: ____________________________ Race: ____________ DOB: ____________________________ Gender: ____________

The above documentation is required to pre-qualify for all Child Development Programs. I certify that, under penalty of perjury, this information is true. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during regular business hours.

Parent/Guardian Signature: ____________________________ Date: ____________________________

White: Office file

Yellow: Site File
CHILD CARE CENTER
NOTIFICATION OF PARENTS’ RIGHTS

PARENTS’ RIGHTS
As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.

2. File a complaint against the licensee with the licensing office and review the licensee’s public file kept by the licensing office.

3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.

4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.

5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.

6. Receive from the licensee the name, address and telephone number of the local licensing office.

   Licensing Office Name: Community Care Licensing
   Licensing Office Address: 2525 Natomas Park Drive, Suite 250, Sacramento, CA 95833
   Licensing Office Telephone #: (916) 263-5744

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.

8. Receive, from the licensee, the Caregiver Background Check Process form.

NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT.AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.

ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS’ RIGHTS
(Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of ____________________________, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS’ RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

   Child Development Programs
   ____________________________
   Name of Child Care Center

   ____________________________                           ____________________________
   Signature (Parent/Authorized Representative)                  Date

NOTE: This Acknowledgement must be kept in child’s file and a copy of the Notification given to parent/authorized representative.
PERSONAL RIGHTS
Child Care Facilities

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.
(a) Child Care Facilities. Each child receiving services from a child care facility shall have rights which include, but are not limited to, the following:

1. To be accorded dignity in his/her personal relationships with staff and other persons.
2. To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
3. To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
4. To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
5. To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In child care facilities, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s) or guardian(s) of the child.
6. Not to be locked in any room, building, or facility premises by day or night.
7. Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME
State of California Department of Social Services    Community Care Licensing

ADDRESS
2525 Natomas Park Drive, Suite 250

CITY
Sacramento

ZIP CODE
95833

AREA CODE/TELEPHONE NUMBER
(916) 263-5744

TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE: PLACE IN CHILD'S FILE

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

ACKNOWLEDGMENT: I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

EDCOE Child Development Programs

6767 Green Valley Road, Placerville, CA 95667

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN) (DATE)

LIC 613A (4/99)
Child’s Name: __________________________ Site/Location: __________________________

Parent/Guardian Printed Name: ______________________________________________________

I give my permission for the El Dorado County Office of Education, Child Development Programs to:  
(Description of each permission is available on the reverse side.)

1. PERMISSION TO ADMINISTER SUNSCREEN Yes No
2. DEVELOPMENTAL ASSESSMENT CONSENT Yes No
3. PHOTOGRAPHS and VIDEO PERMISSION Yes No
4. PHONE NUMBER RELEASE Yes No
5. SCREENING PERMISSION Yes No
6. FLUORIDE TOOTHPASTE Yes No

MY INITIALS NEXT TO EACH PERMISSION LISTED BELOW, AND MY SIGNATURE AT THE BOTTOM OF THE PAGE INDICATE THAT I ACKNOWLEDGE, HAVE READ AND UNDERSTAND EACH PERMISSION LISTED. ALL PARENT INFORMATION IS KEPT IN STRICT CONFIDENCE WITH THIS AGENCY.

7. PERMISSION TO TRANSPORT Initials __________
The parent/guardian acknowledges that the El Dorado County Office of Education, Child Development Program will transport the child/ren in the event of an emergency or disaster to a safe destination, which will be determined by authorities at the time of evacuation.

8. DEPARTMENT INSPECTION AUTHORITY Initials __________
In accordance with section 101200 b & c of the Title 22, Division 12, Chapter 1, Child Care Center Manual of Policies and Procedures, Community Care Licensing: The Department has the authority to interview children or staff, and to inspect and audit child or child care center records, without prior consent. The Department has the authority to observe the physical condition of the child(ren), including conditions that could indicate abuse, neglect or inappropriate placement.

9. CHILD ABUSE and NEGLECT REPORTING ACT Initials __________
Section 11165.7 and Section 11166
“Any child care custodian who knows or reasonably suspects that a child is or has been a victim of child abuse and/or neglect shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone.” “Failure to do so is considered a crime, (Section 11172) since child care custodians are considered mandated reporters.” It is important to remember that the primary purpose of the Child Abuse and Neglect Reporting Act is to protect the child! I understand that the Child Development Programs are mandated child abuse and neglect reporters as indicated by Penal Code, Article 2.5.

Parent/Guardian Signature __________________________ Date __________

White: Office File Yellow: Site File Pink: Parent/Guardian
CHILD PERMISSIONS, continued

Explanation of Child Development Program, Child Permissions needed:

1. **PERMISSION TO ADMINISTER SUNSCREEN**
   Following the recommendation of the California Department of Health Services, our staff will have available, Paba Free SPF 30+ Sunscreen for all children (over 6 months of age) enrolled in the El Dorado County Office of Education, Child Development Programs.

2. **DEVELOPMENTAL ASSESSMENTS CONSENT**
   Parent/guardian gives permission to release the child's assessment results from the Learning Genie and "Desired Results Developmental Profile" (DRDP) for tabulation to produce reports. Birth to three assessments are completed in collaboration with parents. All information is shared on an ongoing basis.

3. **PHOTOGRAPHS and VIDEO PERMISSION**
   The parent/guardian gives permission for the El Dorado County Office of Education, Child Development Programs to use photographs/or video tapes of the child(ren) for marketing and classroom purposes, including but not limited to child's cubby box, classroom projects, child assessment documentation and portfolios etc. Additional notification will be given to request parent/guardian permission if program intends to use child's photograph for Child Development showcase through newspaper, magazine or internet.

4. **PHONE NUMBER RELEASE**
   The parent/guardian gives permission for the El Dorado County Office of Education, Child Development Programs to release the child's home phone number to Child Development Program parents to be used for program activities only.

5. **SCREENING PERMISSION**
   Child Development programs require that each child have on record some or all of the items below:
   
   1. Developmental screening tools  
   2. Speech/Language screening  
   3. Vision screening  
   4. Hearing screening  
   5. Height/weight/head circumference  
   6. Dental screening

   The parent/guardian gives permission for the child to have the above screenings completed during the program year. The parent/guardian understands the results from these screenings will be available to the Child Development staff.

6. **TOOTHPASTE**
   In compliance with Head Start Performance Standard 45 CFR Section 1304.23(b)(3) and recommendations by the American Dental Association, each classroom will have daily tooth brushing. The parent/guardian must indicate whether they want fluoride toothpaste to be used during our daily tooth brushing routine. If the parent/guardian indicates "No" on fluoridated toothpaste, tooth brushing will be done with water.
**CHILD DEVELOPMENT PROGRAMS | HEALTH HISTORY | Form: M-H-211 \ 1819**

**Child's Name**  
**Home Phone**  
**Mother's/Guardian Name**  
**Child's Current Doctor**  
**Medical insurance**  
**Foster Child**

**HEALTH HISTORY**

**Child's Name**  
**Sex**  
**Birthdate**  
**Home Phone**  
**Cell Phone**  
**Site/Class**  
**Father's/Guardian Name**  
**Child's Current Dentist**  
**Kaiser**  
**Private**  
**Other:**

**Does your child have any of the following:**
- Asthma
- Diabetes
- Gastrostomy Tube
- Anemia (low blood iron)
- Myringotomy (tubes in ears)
- Hearing Aids
- Vision Problems (squinting, eyes crossed, "lazy eye")
- Glasses prescribed by doctor
- Is your child exposed to tobacco smoke?
- Does your child use mobility equipment (leg brace, walker, or wheelchair)?
- Seizures
- Heart Problem
- Eczema
- Any major hospitalization/surgery
- Other:

**Social History**

**Have you observed the following in your child?**
- Stumbles
- Bites his/her nails

**What kind of discipline works best with your child?**

**List child's fears or worries:**

**What activities does your child enjoy most?**

**With whom does your child have frequent contact?**

**How do you comfort your child?**

**Does your child use a special comforting item (e.g., blanket)?**

**Do you have any concerns about your child's emotional health?**

**Has your child witnessed any violence?**

**Is there anything else you would like us to know about your child?**

**DEVELOPMENTAL HISTORY**

**Was/is your child:**
- Walking by 14 months?
- Using single words by 18 months?
- Toilet trained now?
- Speaking in full sentences now?

**Do you have concerns:**
- About your child's speech?
- About your child's behavior?
- Other developmental concerns:

**IEP/IFSP:**
- Does your child have an IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan)?

**PREGNANCY/BIRTH HISTORY**

**Please briefly answer the following:**
- Were there complications with pregnancy or birth?
- Did mother use any medications, alcohol, street drugs or tobacco during pregnancy?
- Was the child born early (premature)?

**Birth Weight** _lbs_ _oz_

**MEDICATION**

**Does your child take any medication?** List:

**MEDICATION**

**Does your child need to take any medication at school?** List:

**MEDICATION**

**Signature**  
**Date**  
**Relationship to child**  
**Date**  
**Reviewed by**  
**Title**  
**Date**  
**White - Office file**  
**Canary - Site file**
Child’s Name ___________________________ Birthdate ____________
Teacher ______________________________ Site/Option __________
Parent/Guardian Name __________________ Phone # __________________

1. Yes No Is your child on a special diet or allergic to any foods? If yes, what? __________________________

2. Yes No Is your child on WIC? __________________________

3. Yes No Is your child taking vitamins, iron or fluoride? If yes, what? __________________________

4. Yes No How many meals and snacks does your child eat each day? Meals: ______ Snacks: ______

5. Yes No Is your child drinking from a bottle? If yes, how many times a day? __________________________

6. Yes No Do you have any questions about the way your child is eating? If yes, what? __________________________

Please check the column that shows how often your child eats the following foods. Check only one column for each food.

<table>
<thead>
<tr>
<th>Vegetable/Drink</th>
<th>2-4 Times a Day</th>
<th>Once Daily</th>
<th>2-4 Times a Week</th>
<th>Once Weekly</th>
<th>Hardly Ever or Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red Meat: Beef, Pork</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Luncheon Meats, Hot Dogs, Chicken Nuggets (Circle which is served)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken, Turkey, Fish</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eggs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dried Peas or Beans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanut Butter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal (dry or cooked)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% Whole Wheat Bread, Tortillas: circle one ~ Flour or Corn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice, Noodles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk Circle One: Whole 2% 1% Nonfat Soy Lactaid Other __________</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheese, Yogurt, Sour Cream</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruits: Citrus Fruits oranges, pineapple, grapefruit, tangerines, Kiwi, Cantaloupe, Strawberries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruits: Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juices: Citrus (Orange, pineapple, grapefruit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juices: Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables: Tomatoes, Broccoli, Cabbage, Cauliflower, Brussels Sprouts, Peppers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables: Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soda, Fruit-Flavored Drinks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chocolate or Strawberry Milk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Candy, Cakes, Cookies, Donuts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pizza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potato Chips and Crackers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Parent Signature ___________________________________________ Date: ________________

White: Site file Yellow: Nutrition Coordinator
Please complete this form and return to: Child Development Programs, Health Coordinator
6767 Green Valley Road, Placerville, CA 95667 | PHONE: (530) 295-2270 / 295-2276 or FAX: (530) 295-1935

** Note: If any section is left blank, this form will be returned to attending Physician/Healthcare Provider for completion.

<table>
<thead>
<tr>
<th>* HEIGHT:</th>
<th>* WEIGHT:</th>
<th>* BLOOD PRESSURE:</th>
</tr>
</thead>
</table>

** SCREENING OF TB RISK FACTORS **

Are TB Risk Factors Present?  
☐ No; TB Skin Test NOT Required  
☐ Yes; TB Skin Test Required

☐ Risk Factors PRESENT; TB Skin Test or CXR REQUIRED  
PPD Date Given:  
Date Read:  
Positive  
Negative

☐ Risk Factors PRESENT; TB Skin Test or CXR REQUIRED  
Chest X-ray Date:  
Positive  
Negative

☐ Risk Factors NOT present; Hgb Blood Test NOT Required  
RESULTS:  
Receiving Treatment:  
Date:  
☐ YES  
☐ NO

☐ Risk Factors NOT present; Lead Blood Test NOT Required  
RESULTS:  
Receiving Treatment:  
Date:  
☐ YES  
☐ NO

<table>
<thead>
<tr>
<th>* VISION *</th>
<th>* HEARING *</th>
</tr>
</thead>
</table>

LEFT EYE:  
☐ Pass  
☐ Fail

RIGHT EYE:  
☐ Pass  
☐ Fail

LEFT EAR:  
☐ Pass  
☐ Fail

RIGHT EAR:  
☐ Pass  
☐ Fail

Describe or Check Method Used:  
☐ LEA  
☐ Sure Sight  
☐ OAE  
☐ ABR

** HEMOGLOBIN **

☐ Risk Factors NOT present; Hgb Blood Test NOT Required  
RESULTS:  
Receiving Treatment:  
Date:  
☐ YES  
☐ NO

<table>
<thead>
<tr>
<th>* LEAD *</th>
</tr>
</thead>
</table>

☐ Risk Factors NOT present; Lead Blood Test NOT Required  
RESULTS:  
Receiving Treatment:  
Date:  
☐ YES  
☐ NO

** EXAMINATION RESULTS **

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>DESCRIBE FINDINGS/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL APPEARANCE / SKIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEAD / EARS / EYES / NOSE / THROAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEART / LUNGS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABDOMEN / GENITOURINARY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXTREMITIES / SKELETAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEUROLOGICAL (Fine, Gross Motor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPEECH / LANGUAGE</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| DENTAL ASSESSMENT  
Dental Referral:  
☐ YES  
☐ NO |
| NUTRITIONAL ASSESSMENT |
| SOCIAL / BEHAVIORAL ASSESSMENT |
| DEVELOPMENTAL SURVEILLANCE |
| TOBACCO ASSESSMENT  
Exposed to Secondhand Smoke:  
☐ YES  
☐ NO |
| ALLERGIES (List)  
Food Allergy:  
☐ YES  
☐ NO  
Seasonal:  
☐ YES  
☐ NO  
Other:  
☐ YES  
☐ NO |

Health Concerns / Diagnoses:

Medications:  
☐ Taken at Home?  
☐ NO  
List:  
☐ Required at School?  
☐ NO  
List:

IMMUNIZATIONS – Please attach a printout of immunizations received at today's visit.

PHYSICIAN'S SIGNATURE:  
DATE OF EXAM:  
MEDICAL GROUP NAME:  

ADDRESS:  
PHONE:  
FAX:  

Blue Original – Office file  
Blue Copy – Site file  
Copy – Health Coordinator  
(rev. 03/2018)