THE NAVAJO NATION

P.O. Box 9000 • Window Rock, Arizona 86515 • (928) 871-6000

Ben Shelly
President

Rex Lee Jim
Vice President

NHSPC 219-01-2014

RESOLUTION OF THE
NAVAJO HEAD START POLICY COUNCIL

NAVAJO HEAD START POLICY COUNCIL SUPPORTS AND APPROVES THE IMPLEMENTATION OF THE NAVAJO HEAD START ANNUAL REVISION OF POLICY & PROCEDURES (INCLUDING FORMS, PROFESSIONAL DEVELOPMENT, FLOW CHART & TRACKING) AND SERVICE DELIVERY PLANS 2013-2014 IN THE AREA OF HEALTH & NUTRITION.

WHEREAS:

1. The Navajo Nation Board of Education (hereinafter the "Board" is the education agent in the Executive Branch for the purposes of overseeing the operation of all schools serving the Navajo Nation, including the Navajo Head Start program. 10 N.N.C. §106[A]; 10 N.N.C. §51. The Board carries out its duties and responsibilities through the Department of Diné Education. 10 N.N.C. §106[G][3]; and

2. Pursuant to 45 CFR 1304-50. Program Governance and Appendix A. The Navajo Nation Head Start Policy Council is duly elected and constituted Head Start Policy Council and an authorized entity of the Navajo Nation government; and

3. Pursuant to 45CFR 1304.51(a)(1)(iii) Management Systems and procedures-Program planning must include: the development of written plans(s) for implementing service in each of the program areas covered by this part (e.g. Early Childhood Development and Health Services, Family and Community Partnership, and program Design and Management);

4. Pursuant to 45 CFR 1304.51 (a)(2) All written plans for implementing services, and the progress in meeting them, must be reviewed by the grantee staff and revie2ed and approved by the Policy Council or Policy Committee at least annually, and must be revised and updated as needed; and

5. Pursuant to 45 CFR 1304.20 Health and Developmental Services. Grantee must determine health status; Screen for developmental, sensory and behavioral concerns; Extended follow up and treatment; Ongoing Care and Individualization of the program; and

6. Pursuant to 45 CFR 1304.23 Child Nutrition. Identification of nutritional needs. Staff and families must work together to identify each child's nutritional needs, taking into account staff and family discussions concerning; Grantee and delegate agencies must design and implement a nutrition program that meets the nutritional needs and feeding requirements of each child, including those with special dietary needs and children with disabilities. Also, the nutrition program must serve a variety of foods which consider cultural and ethnic preferences and which broaden the child's food experience; and

7. The purpose of Navajo Head Start is to promote the school readiness of low-income children by enhancing their cognitive, social and emotional development: **(a)** in a learning environment that supports children's growth in language, literacy, mathematics, science, social and emotional functioning, creative arts, physical skills, and approaches to learning; and **(b)** through the provision to low-income children and their families of health, educational nutritional social, and other services based on family needs assessment; and

8. Navajo Head Start provides children with experiences that encourage and stimulate intellectual and social growth opportunities, promote Navajo Language and culture, and provides access to necessary medical, dental, and nutritional services under the Head Start and Early Head Start programs; and

9. The Navajo Nation Head Start Policy Council has the best interest of the Navajo Head Start to continue in providing quality services to children and families.

NOW, THEREFORE BE IT, RESOLVED:

Supports and approves the implementation of the Navajo Head Start Annual Revision of Policy & Procedures (including forms, professional development, flow chart & tracking) and Service Delivery Plans 2013-2014 in the area of Health & Nutrition.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Navajo Head Start Policy Council at a duly called meeting in **Window Rock, AZ** at the DoDE Education Building which a quorum was present and that it was passed by vote of 12 in favor, 0 opposed, and 2 abstained, this **23rd** day of **January 2014.**

Motion by: Gregory Nells

Second by: Brady Clark

Olin Kieyoomia, President
DODE/Navajo Head Start Policy Council

DEPARTMENT OF DINÉ EDUCATION
THE NAVAJO NATION
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Ben Shelly
President

Rex Lee Jim
Vice-President

NNBEJA-NHS-010-2014

RESOLUTION OF THE NAVAJO NATION BOARD OF EDUCATION

Approving the Implementation of the Navajo Head Start annual revision of policy & procedures (including forms, professional development, flow charts, and tracking) and Service Delivery plans 2013-2014 in the area of Health and Nutrition Services.

WHEREAS:

1. The Health, Education, and Human Services Committee is the oversight committee for the Department of Diné Education and Navajo Nation Board of Education [2 N.N.C. § 401 (C)(1); 10 N.N.C. § 1(B)]; and

2. The Navajo Nation Board of Education (hereinafter the "Board") is the education agent in the Executive Branch for the purposes of overseeing the operation of all schools serving the Navajo Nation. [10 N.N.C. § 106 (A)] The Board carries out its duties and responsibilities through the Department of Diné Education (hereinafter the "Department") [10 N.N.C. §106 (G)(3)]; and

3. The Department of Diné Education (hereinafter the "Department") is the administrative agency within the Navajo Nation with responsibility and authority for implementing and enforcing the educational laws of the Navajo Nation. 2 N.N.C. §1801(B); 10 N.N.C. §107(A). The Department is under the immediate direction of the Navajo Nation Superintendent of Schools, subject to the overall direction of the Navajo Nation Board of Education. 10 N.N.C. §107(B); and

4. The Navajo Head Start ("NHS") Program, which is located within the Department of Diné Education as approved by the Department's Plan of Operation, Resolution No. GSCMY-19-07. The NHS also is funded by a grant from the Office of Head Start, Administration of Children and Families (ACF), under the terms of the Head Start Act, 42 U.S.C. §9801 *et seq.*, and applicable regulations; and,

5. The Navajo Nation is named the grantee and is responsible for ensuring compliance with the Head Start Act and performance standards in delivering the services to Navajo children and their families. The 2013-2014 Navajo Head Start Policy and Procedures and Service Delivery Plans is revised annually for implementation of Head Start/Early Head Start services
6. The Board acknowledges the Navajo Head Start Resolution #219-01-2014 passed on January 23, 2014, Approving the Navajo Head Start to implement the policy and procedures

and service delivery plans, as it relates to services within the program; and Recommending Approval through the Navajo Nation Board of Education, and the Health, Education, and Human Services Committee of the Navajo Nation Council.

NOW THEREFORE BE IT RESOLVED THAT:

1. The Navajo Nation Board of Education hereby approves the Navajo Head Start Policy and Procedures and Service Delivery Plans.

2. The Navajo Nation Board of Education further recommends that the Navajo Nation Superintendent of Schools or his designee(s) and other designated members of the Navajo Nation Council to advocate on behalf of the Navajo Nation consistent with the services stated in this resolution.

3. The Navajo Nation Board of Education hereby directs and empowers the Superintendent of Schools to take any actions deemed as necessary and proper to carry out the purposes of this resolution.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Board of Education of the Navajo Nation at a duly called meeting at Window Rock, Arizona (Navajo Nation) at which a quorum was present, motion by Katherine D. Arviso and seconded by Gloria Johns and that the same was passed by a vote of 5 in favor; 0 opposed; 0 abstained, this 29th day of January 2014.

Jimmie C. Begay, President
Navajo Nation Board of Education

1304.23 Child Nutrition				
Performance Standard	**NHS Plan of Action**	**Time Frame**	**Responsibility**	**Reference**
1304.23(a) - Identification of nutritional needs. Staff and families must work together to identify each child's nutritional needs, taking into account staff and family discussions concerning:	Each family will complete a health and nutrition history for their child at enrollment.	Enrollment	Health/NutritionSpec. Quality Assurance Manager ERSEA HS Engagement Spec.	Policies/Procedures Childplus Database
1304.23(a)(1) - Any relevant nutrition-related assessment data (height, weight, hemoglobin/hematocrit) obtained under 45 CFR 1304.20 (a);	Information will be obtained from age appropriate growth assessment well child care per EPSDT guidelines and per HSAC recommended screenings.	Within 90 days of enrollment.	Health/Nutrition Spec. ERSEA Spec. and Liaison	Policies/Procedures
1304.23(a)(2) - Information about family eating patterns, including cultural preferences, special dietary requirements for each child with nutrition-related health problems, and the feeding requirements of infants and toddlers and each child with disabilities (see 45 CFR 1308.20)	Information from health/nutrition history, physical exam and/or Individual Health Care Plan, CACFP meal component requirements, and IEP/IFSP will be used to plan and individualize food service for children.	Enrollment On-going	Health/Nutrition Spec. ERSEA Spec. and Liaison	Policies/Procedures Chilplus Database
1304.23(a)(3) - For infants and toddlers, current feeding schedules and amounts, and types of food provided, including whether breast milk or formula and baby food is used; meal patterns; new foods introduced: food intolerances and preferences, voiding patterns; and observations related to developmental changes in feeding and nutrition. This information must be shared with parents and updated regularly, and	Infants/toddler classrooms will work together with parents to establish/maintain feeding schedules, amounts and types of food/milk,meal patterns, introduction of new foods, developmental changes, voiding patterns. This information will be updated regularly and shared with parents.	Enrollment Monthly As needed	Health/Nutrition Spec.	Policies/Procedures Childplus Database
1304.23(a)(4) - Information about major community nutritional issues, as identified through the Community Assessment or by the Health Services Advisory Committee or the local health department.	The Health Services Advisory Committee, with representation of the local health department, will review the Community Assessment and will be asked for any additional input on community nutritional issues.	Quarterly	Health/Nutrition Spec & Liaison Engagement Spec.	Policies/Procedures
1304.23(b)(1) - Grantee and delegate agencies must design and implement a nutrition program that meets the nutritional needs and feeding requirements of each child, including those with special dietary needs and children with disabilities. Also, the nutrition program must serve a variety of foods which consider cultural and ethnic preferences and which broaden the child's food experience.	Accommodations/diet modifications will be made for all children with food intolerances/allergies or religious or cultural preferences. The program will integrate a variety of foods, methods of preparation, and a range of available fruits and vegetables into food service and include a variety of classroom food experiences into the classroom curriculum.	Annually (2 times for Staff and once for parent)	Health/Nutrition Spec. & Liaison ERSEA Engagement Spec. Mental Health/Disability Coordi.	Policies/Procedures NM/Menu RecordBook Production Worksheets CACFP Monitoring
1304.23(b)(1)(i) - All Early Head Start and Head Start grantee and delegate agencies must use funds from USDA Food and Consumer Services Child Nutrition Programs as the primary source of payment for meal services. Early Head Start and Head Start funds may be used to cover those allowable cost not covered by the USDA.	Budget will indicate inclusion of CACFP reimbursements as primary source of payment for food services, and will show Head Start/EHS funding as secondary source.	Annually	Assistant Superintendent Health/Nutrition Spec. Quality Assurance Mgr. Manager	Policies/Procedures CACFP Renewal Application

1304.23(b)(1)(ii) - Each child in a part-day center-based setting must receive meals and snacks that provide at least 1/3 of the child's daily nutritional needs. Each child in a center-based full-day program must receive meals and snacks that provide 1/2 to 2/3 of the child's daily nutritional needs, depending upon the length of the program day.	The program will use CACFP meal patterns for creating menus and have menus reviewed by a Registered Dietitian to ensure appropriate nutrition needs are met for program option.	Annually	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures NHS Menus NM/Menu Record Book AZ/Production Worksheets
1304.23(b)(1)(iii) - All children in morning center-based settings who have not received breakfast at the time they arrive at the Early Head Start or Head Start program must be served a nourishing breakfast.	Staff will serve children a nutritious breakfast if they arrive after scheduled breakfast time.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures Daily Sign/In Sheet
1304.23(b)(1)(iv) - Each infant and toddler in center-based settings must receive food appropriate to his or her nutritional needs, developmental readiness, and feeding skills, as recommended in the USDA meal pattern or nutrient standard menu planning requirements outlined in 7 CFP parts 210, 220, and 226.	Program will follow infant/toddler CACFP meal patterns for age, individualizing for nutritional needs, developmental readiness and feeding skills.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(b)(1)(v) - For 3 – to - 5 years in center-based settings, the quantities and kinds of food served must conform to recommended serving sizes and minimum standards for meal patterns recommended in the USDA meal pattern or nutrient standard menu planning requirements outlined in 7 CFR parts 210, 220, and 226.	Program will follow CACFP requirements and meal patterns for ages 3-5 years of age.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures NM/Menu Record Book AZ/Production Worksheet
1304.23(b)(1)(vi) - For 3 – to – 5 years old in center-based settings or other Head Start group experiences, foods served must be high in nutrients and low in fat, sugar, and salt.	Program will use CACFP creditable foods, meal patterns and menus will be reviewed by a Registered Dietitian to ensure foods are low in fat, sugar and high in nutrients.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(b)(1)(vii) - Meal and snack periods in center-based settings must be appropriately scheduled and adjusted, where necessary, to ensure that individual needs are met. Infants and young toddlers who need it must be fed "on demand" to the extent possible or at appropriate intervals.	Program will follow CACFP guidelines for meals, individual needs will be accommodated. Infants/toddlers will be fed on demand to the extent possible.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(b)(2) - Grantee and delegate agencies operating home-based program options must provide appropriate snacks and meals to each child during group socialization activities (see 45 CFR 1306.33 for information regarding home-based group socialization)	Group socializations will follow the CACFP/RD approved menus as center-based classrooms for meal service.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(b)(3) - Staff must promote effective dental hygiene among children in conjunction with meals.	Children will brush teeth after each meal service per day, including gum wiping for infants.	Daily	Health/Nutrition Spec. Quality Assurance Manager Center Staff	Policies/Procedures

1304.23(b)(4) - Parents and appropriate community agencies must be involved in planning, implementing, and evaluating the agencies' nutritional services.	Members of Health Service Advisory Committee, which includes parents and community agency representatives, will review program food service annually.	Annually	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(c) - Meal Service Grantee and delegate agencies must ensure that nutritional services in center-based settings contribute to the development and socialization of enrolled children by providing that: 1304.23(c)(1) - A variety of food is served which broadens each child's food experiences;	Menus will reflect a range of food and different ways foods are prepared.	Annually	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures NHS Menus
1304.23(c)(3) - Sufficient time is allowed for each child to eat;	Mealtimes will follow CACFP recommended times for meal service, children will be allowed to eat at their own pace.	As needed.	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(c)(4) - All toddlers and preschool children and assigned classroom staff, including volunteers, eat together family style and share the same menu to the extent possible;	Family style meal service will be used in classrooms to the extent possible.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(c)(5) - Infants are held while being fed and are not laid down to sleep with a bottle;	Infants will be held during feeding and not laid down with a bottle.	On-going	Health/Nutrition Spec. Quality Assurance Manager EHS Staff	Policies/Procedures
1304.23(c)(6) - Medically-based diets or other dietary requirements are accommodated; and	Medically based diets or other dietary requirements will be accommodated per physician recommendation.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(c)(7) - As developmentally appropriate, opportunity is provided for the involvement of children in food-related activities.	Children will participate in a developmentally appropriate food related activities at least twice per month	Twice	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(d) - Family assistance with nutrition. Parent education activities must include opportunities to assist individual families with food preparation and nutritional skills.	Program will offer nutrition education to families once a month.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(e)(1) - Grantee and delegate agencies must post evidence of compliance with all applicable Federal, State, Tribal, and local food safety and sanitation laws, including those related to the storage, preparation and service of food and the health of food handlers. In addition, agencies must contract only with food service vendors that are licensed in accordance with State, Tribal, or local laws.	Program staff will post current food handler's certification and center based surveys by Office of Environmental Health.	On-going	Health/Nutrition Spec. Quality Assurance Manager Support Service Manager	Policies/Procedures
1304.23(e)(2) - For programs serving infants and toddlers, facilities must be available for the proper storage and handling of breast milk and formula.	Infant toddler classrooms will facilities for the storage and handling of breast milk and formula.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures

Child Health and Developmental Services					
Performance Standard	**NHS Plan of Action**	**Time Frame**	**Responsible Person**	**Reference**	
1304.20 - Child Health and Developmental Services 1304.20(a) - Determining Child Health Status 1304.20(a)(1) - In collaboration with the parents and as quickly as possible, but no later than 90 calendar days (with the exception noted in paragraph (a)(2) of this section) from the child's entry into the program (for the purposes of 45 CFR 1304.20 (a)(1), 45 CFR 1304.20 (a)(2), and 45 CFR 1304.20 (b)(1), "entry" means the first day that Early Head Start or Head Start services are provided to the child), grantee and delegate agencies must: 1304.20(a)(1)(i) - Make a determination as to whether or not each child has an ongoing source of continuous, accessible health care. If a child does not have a source of ongoing healthcare, grantee and delegate agencies must assist the parents in accessing a source of care;	At enrollment, families complete health/nutrition histories, and other enrollment documents which provide information about their ongoing source of continuous, accessible health care. If children do not have a medical/dental home and health coverage, program staff will work with families to establish a medical home and make referrals to providers.	At enrollment	Health and Nutrition Quality Assurance Manager	Policies/Procedures	
1304.20(a)(1)(ii) - Obtain from a health care professional a determination as to whether the child is up-to-date on a schedule of age appropriate preventative and primary health care which includes medical, dental, and mental health. Such a schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate, and the latest immunization recommendations issued by the Center for Disease Control and Prevention, as well as any additional recommendations from the local Health Services Advisory Committee that are based on prevalent community health problems:	At enrollment, staff work with parents to establish if child is on a schedule of well child care, including referral for current EPSDT exam, immunizations and dental exam if needed. With parental permission, staff will request information from providers if needed.	At enrollment	Health and Nutrition Quality Assurance Manager	Policies/Procedures	
1304.20(a)(1)(ii)(A) - For children who are not up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must assist parents in making the necessary arrangements to bring the child up-to-date;	When it is established a child is not up-to-date on a schedule of well child care, program staff will work with parents to understand what service the child needs, why it is important and will assist parent as needed to complete the service.	Enrollment and monthly	Health and Nutrition Quality Assurance Manager	Policies/Procedures	
1304.20(a)(1)(ii)(B) - For children who are up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must ensure that they continue to follow the recommended schedule of well child care; and;	Staff will reveiw ChildPlus reports and child files periodically to allow them to alert parents ahead of time to schedule new health exams and dental exams to keep their child up-to-date.	Monthly	Health and Nutrition Quality Assurance Manager	Policies/Procedures	

1304.20(a)(1)(ii)(C) - Grantee and delegate agencies must establish procedures to track the provision of health care services.	Program will use ChildPlus computer database program to monitor and track the provision of health care services. Staff will run reports on a regular basis and review to identify gaps in service, expiring health events, and monitor progress of referrals or treatment.	Monthly	Health and Nutrition Quality Assurance Manager	Policies/Procedures	
1304.20(a)(1)(iii) - Obtain or arrange further diagnostic testing, examination, and treatment by an appropriate licensed or certified professional for each child with an observable, known or suspected health or developmental problem; and 1304.20(a)(1)(iv) - Develop and implement a follow-up plan for any condition identified in 45 CFR 1304.20 (a)(1)(ii) and (iii) so that any needed treatment has begun.	For each child with an observable, known or suspected health problem, staff, in partnership with parents, will refer children for further evaluation and treatment by appropriate professional. Staff will also develop and implement a plan so that follow-up treatments is started and completed if possible.	As needed	Health and Nutrition Quality Assurance Manager	Policies/Procedures	
1304.20(b) - Screening for developmental, sensory, and behavioral concerns 1304.20(b)(1)/(2) - In collaboration with each child's family, and within 45/90 calendar days of the child's entry into the program, grantee and delegate agencies must perform or obtain linguistically and age appropriate screening procedures to identify concerns regarding a child's developmental, sensory (visual and auditory), behavioral, motor, language, social, cognitive, perceptual, and emotional skills (see 45 CFR 1308.6(b)(3) for additional information). To the greatest extent possible, these screening procedures must be sensitive to the child's cultural background. 1304.20(b)(2) - Grantee and delegate agencies must obtain direct guidance from a mental health or child development professional on how to use the findings to address identified needs. 1304.20(b)(3) - Grantee and delegate agencies must utilize multiple sources of information on all aspects of each child's development and behavior, including input from family members, teachers, and other relevant staff who are familiar with the child's typical behavior.	Program will provide appropriately trained staff or coordinate with qualified community partners to screen children within 45 days of enrollment. The program will adopt age-appropriate and culturally sensitive screening tools and procedures. Staff will utilize contracted mental health professionals or other child development professionals for guidance on how to use screening findings to address individual child needs. Staff will gather information about each child from parents, teachers and other staff members who are familiar with the individual child to gather a complete picture of each child's development. Program will provide approiately trained staff or coordinate with qualified community partners to review and complete health requirements within 90 days of enrollment. Program will provide appropriate trained staff on growth assessment. Continue to coordinate with qualified community partners to screen children within the 90 days of enrollment. Growth Assessment will continue until completed.	Within 45/90 days of enrollment On-Going Monitoring	Health and Nutrition Specialist Disability Specialist Mental Health Coordinator School Raediness Coaches School Readiness Manager	Policies and Procedures ChildPlus Review Folders Tracking reports FSL Contact Logs	

1304.20(c) - Extended follow-up and treatment 1304.20(c)(1) - Grantee and delegate agencies must establish a system of ongoing communication with the parents of children with identified health needs to facilitate the implementation of the follow-up plan. 1304.20(c)(2) - Grantee and delegate agencies must provide assistance to the parents, as needed, to enable them to learn how to obtain any prescribed medications, aids or equipment for medical and dental conditions. 1304.20(c)(3) - Dental follow-up and treatment must include; 1304.20(c)(3)(i) - Fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and 1304.20(c)(3)(ii) - Other necessary preventive measures and further dental treatment as recommended by the dental professional.	1. Staff will consult with parent to create a follow-up plan when a health need is identified. 2. Staff will assist parents through education or referrals, if needed, to learn how to obtain medication, aids or equipment for medical/dental conditions. 3. Staff will assist parents if needed, to access dental treatment and follow-up that may include additional fluoride or topical fluoride, along with regular, routine professional preventative dental visits and to complete any dental treatment as prescribed.	As needed	Health and Nutrition Specialist Health and Nutrition Coordinator	Policies/Procedures	
1304.20(c)(4) - Grantee and delegate agencies must assist with the provision of related services addressing health concerns in accordance with the Individualized Education Program (IEP) and the Individualized Family Service Plan (ISFP).	Staff will review IEP/IFSP for health related services and create a follow-up plan to address them.	As needed	Health and Nutrition Specialist Health and Nutrition Coordinator Disability Specialist	Policies/Procedures	
1304.20(c)(5) - Early Head Start and Head Start funds may be used for professional medical and dental services when no other source of funding is available. When Early Head Start or Head Start funds are used for such services, grantee and delegate agencies must have written documentation of their efforts to access other available sources of funding.	Program will annually set aside funding to reserve for medical or dental services for children if needed. Program staff must document all efforts to link child to other available resources prior to using this funding.	Annually	Assistant Superintendent Health and Nutrition Quality Assurance Manager Health and Nutrition Specialist Health Nutrietion Coordinator	Policies/Procedures	

1304.20(d) - Ongoing Care. In addition to assisting children's participation in a schedule of well child care, as described in section 1304.20(a) of this part, grantee and delegate agencies must implement ongoing procedures by which Early Head Start and Head Start Staff can identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals. These procedures must include: periodic observations and recordings, as appropriate, of individual children's developmental progress, changes in physical appearance (e.g., signs of injury or illness) and emotional and behavioral patterns. In addition, these procedures must include observations from parents and staff.	Through the process of 45 day screenings, dental screenings by staff, and health and dental exams by professionals health concerns may be identified. In addition to this process, teachers will make and record daily observations of individual children and daily health checks will take place. In the event of changes in physical behavioral/emotional patterns of individual children, parents will be consulted. Parental observations will be solicited when observed changes occur and during home visits and parent/teacher conferences.	As needed	Health and Nutrition Quality Assurance Manager Indian Health Services NN Division of Health 1st Things First (AZ) BYU Nutrition Awareness University of Colorado Denistry Young Orthodox 638 Programs Coconino County Summit Health Care (AZ)	Policies/Procedures	
1304.20(e) - Involving Parents. In conducting the process, as described in sections 1304.20 (a), (b), and (c), and in making all possible efforts to ensure that each child is enrolled in and receiving appropriate health care services, grantee and delegate agencies must: 1304.20(e)(1) - Consult with parents immediately when child health or developmental problems are suspected or identified; 1304.20(e)(2) - Familiarize parents with the use of and rationale for all health and developmental procedures administered through the program or by contract or agreement, and obtain advance parent or guardian authorization for such procedures. Grantee and delegate agencies also must ensure that the results of diagnostic and treatment procedures and ongoing care are shared with and understood by the parents; 1304.20(e)(3) - Talk with parents about how to familiarize their children in a developmentally appropriate way and in advance about all of the procedures they will receive while enrolled in the program; 1304.20(e)(4) - Assist parents in accordance with 45 CFR 1304.40 (f)(2)(i) and (ii) to enroll and participate in a system of ongoing family health care and encourage parents to be active partners in their children's health care process; and: 1304.20(e)(5) - If a parent or other legally responsible adult refuses to give authorization for health services, grantee and delegate agencies must maintain written documentation of the refusal.	1. Teachers will make general observations of individual children throughout the day, noting changes in physical appearance, developmental and social emotional behavior in addition to daily health check and will notify parents immediately if significant changes are observed. 2. During enrollment and when needed, staff will explain to parents why screenings, health and dental exams are important to the health and well being of their child prior to asking them to sign consents for screenings or health/dental exams arranged by the program. The results of these screenings/exams will be shared with parent on first home visit by the teacher, unless there are concerns raised during screening/exam. It that event, parents will be notified as soon as possible. 3. During enrollment and when needed, staff will talk to parents about how the parents can work with their child to help the child be more comfortable with the screenings/exam procedures. 4. At enrollment and when needed, staff will help parents enroll in a system of ongoing family health care and will encourage parents to actively participate in their child's health care by being informed consumers, make and keeping provider appointments and following through with any required treatment or further evaluation. 5. If parents/guardians indicate they are refusing any health/developmental services, after explanation of reason for service by staff, they will be asked to sign a refusal of services.	Enrollment As needed	Health and Nutrition Quality Assurance Manager	Policies/Procedures	

1304.20(f) - Individualization of the program 1304.20(f)(1) - Grantee and delegate agencies must use the information from the screening for developmental, sensory, and behavioral concerns; the ongoing observations, medical and dental evaluations and treatments, and insights from the child's parents to help staff and parents determine how the program can best respond to each child's individual characteristics, strengths and needs. 1304.20(f)(2) - To support individualization for children with disabilities in their programs, grantee and delegate agencies must assure that; 1304.20(f)(2)(i) - Services for infants and toddlers with disabilities and their families support the attainment of the expected outcomes contained in the individualized Family Service Plan (IFSP) for children identified under the infants and toddlers with disabilities program (Part C) of the Individuals with Disabilities Education Act, as implemented by their State or Tribal government; 1304.20(f)(2)(ii) - Enrolled families with infants and toddlers suspected of having a disability are promptly referred to the local early intervention agency designated by the State Part C plan to coordinate any needed evaluations, determine eligibility for Part H services, and coordinate the development of an IFSP for children determined to be eligible under the guidelines of that State's program. Grantee and delegate agencies must support parent participation in the evaluation and IFSP	1. Program will individualize for nutrition/health/dental co	Enrollment As needed	Health and Nutrition Quality Assurance Manager Disabilities/Mental Health Quality Assurance Manager Education Quality Assurance Manager	Policies/Procedures	

Navajo Head Start/Early Head Start
Medication Administration Procedure

Head Start Program Performance Standards: 1304.22(c) (1-6)
(c) Medication administration. Grantee and delegate agencies must establish and maintain written procedures regarding the administration, handling, and storage of medication for every child. Grantee and delegate agencies may modify these procedures as necessary to satisfy State or Tribal laws, but only where such laws are consistent with Federal laws. The procedures must include:

(1) **Labeling and storing, under lock and key, and refrigerating, if necessary**, all medications, including those required for staff and volunteers;

(2) **Designating a trained staff member**(s) or school nurse to administer, handle and store child medications;

(3) **Obtaining physicians' instructions and written parent or guardian authorizations** for all medications administered by staff;

(4) **Maintaining an individual record** of all medications dispensed, and **reviewing the record regularly** with the child's parents;

(5) **Recording changes in a child's behavior** that have implications for drug dosage or type, and **assisting parents in communicating with their physician** regarding the effect of the medication on the child; and

(6) Ensuring that appropriate staff members can **demonstrate proper techniques** for administering, handling, and storing medication, including the use of any necessary equipment to administer medication.

Medication Storage and Labeling

Prescribed medication shall be in the original container **labeled** by a Pharmacist with the following:

- Child's first and last name
- Medication name
- Date the Prescription was filled
- Dosage
- Name of the prescribing Healthcare Provider
- Expiration date of the medication. No medication shall be dispensed to a child after the expiration date on the label.

a. Prescription Medication shall be accompanied by the Drug Fact Sheet/Patient Insert provided by the Pharmacist and **stored** per manufacturer's or pharmacist instructions.
b. Rescue Medications such as EpiPens for severe allergic reaction and rescue Inhalers for asthma shall be kept in a child resistant locking bag, so that it is maintained locked and inaccessible to children, yet readily accessible to staff. Trained staff will carry medication in a fanny pack on playground, field trips and bus routes. Classrooms must maintain the medication in locking bag where all staff members are aware of location, and medication is inaccessible to children.

Over the Counter Medication (OTC):

a. OTC medications will not be given without a written Health Care Provider order. Order should include Child Name, Dosage, Route, When and How Long the medication should be given, and the condition for which it should be given.
b. OTC Medications must be in an original child resistant container with a legible label for dosing and side effects, and expiration date. Medication shall not be dispensed after the expiration date.

c. OTC Medication shall be stored according to manufacturer's storage recommendations and locked and inaccessible to children.

Medication Required By Staff:

All Prescription and Over the Counter medications required by staff shall be labeled, stored and maintained as per child medication. However, adult medications should be stored in a separate locked box from children's medications. Staff purses should be maintained in a locked area while children are present on site. It is highly recommended to notify another staff about your medical condition, as well as the prescribed medication(s).

Storage and Inaccessibility to Children:

a. All Medication shall be stored in a secure, locked location inaccessible to children and separate from food.
b. Medication requiring refrigeration shall be stored in a locked box in a refrigerator that is separate from food refrigeration.
c. Medication shall be stored in separate zip type bags for each person requiring medication. The bags shall be labeled with child's name, and all required paperwork and drug fact/patient insert sheets shall be in the bag.
d. No more than a four week supply of medication will be accepted at one time.
e. Rescue Medications such as EpiPens for severe allergic reaction and rescue Inhalers for asthma shall be kept in a child resistant locking bag, so that it is maintained locked and inaccessible to children, yet readily accessible to staff. Trained staff will carry medication in a fanny pack on playground, field trips and bus routes. Classrooms must maintain the medication in locking bag where all staff members are aware of location, and medication is inaccessible to children.

Transporting Medication:

a. Parents cannot give medication to bus drivers or monitors to take to Head Start. Parents are responsible for bringing the medication to the classroom, completing all required Medication Administration paperwork, and verifying with responsible staff that the medication is properly labeled.
b. Medication cannot be transported by the student or in the student's back pack.
c. Medication required for a field trip shall be transported in a child resistant locked box with all required paperwork or in a fanny pack by a medication trained staff person.
d. In the event a child that rides the bus regularly requires rescue medication, training will be arranged for the bus driver and the bus monitor prior to the child riding the bus.

General Medication Training for Staff:

a. All staff shall be trained on general medication storage, administration procedures, safeguards, emergency medication procedures for Epipens and use of inhalers/nebulizers for asthma annually.
b. Medication training records will be kept at centers per Office of Environmental Health requirements.

c. Medication that requires injection other than Epipens for severe allergic reactions, will be administered by a Licensed Health Care Provider or designee, depending on local/state laws.
d. Training will be arranged for staff working with a child with special health conditions or medications. Parents will orient staff to use of medication/equipment. For more severe conditions, health care providers may need to offer the training to staff.
e. Trained staff members who are designated to administer medications in classrooms are as follows: teachers, teacher assistants, and bus drivers. The bus monitor will be trained in the event a child who rides the bus routinely may need a rescue medication during regular transport.

Parent Orientation for Medication: Navajo Head Start shall provide parent orientation the procedures and policies for Medication Administration at the beginning of the school year and individually if their child requires medication while at school.

Parent Responsibilities:

a. Parents are responsible to bring the child's medication to the center, complete all required paperwork and to verify with staff that medication is properly labeled.
b. Staff will not accept medication that is not labeled according to policy.
c. Parents, along with health care provider, should arrange when possible to give medication before or after school.
d. Parents must give first dose of medication at home.

Physicians' instructions and written authorization from parent or legal guardian:

a. Prescription Medications shall be accompanied by a written health care provider order in the form of the prescription label.
b. OTC medications will not be given without a written Health Care Provider order. Order should include Child Name, Dosage, Route, When and How Long the medication should be given, and the condition for which it should be given.
c. OTC Medications must be in an original child resistant container with a legible label for dosing and side effects, and expiration date. Medication shall be not be dispensed after the expiration date
d. Parental Consent and Parent Authorization must accompany the medication and kept on file.
e. All medication shall be accounted for. Spills or spoilage of medication shall be documented and kept on file. Parents shall be notified of medication loss.
f. Refusal to take medication shall be documented and shared with parents as soon as possible.
g. Designated staff shall immediately notify Healthcare provider of any reactions to medication and follow the directions of the Healthcare Provider and parents should be notified also at this time.

Individual Records:

a. Navajo Head Start shall maintain individual records of all medications dispensed and review the child's record with the parents/guardians on a regular basis, at least weekly for regularly dispensed medications, review with parent should be documented on the Medication Dispensation Log.
b. Medication Dispensation Log shall be documented at the time child's medication is administered.
c. Refusal to take medication shall be documented on the Medication Dispensation Log.
d. Adverse reaction or changes in child's behavior shall be documented on the Medication Dispensation Log.
e. Spills or spoilage of Medication shall be documented on the Medication Dispensation Log.
f. Medication logs shall be reviewed with parents on a regular basis.

Recording a child's behavior caused by implications of medication dosage and will assist parents in consulting with their child's physician regarding medication.

a. Staff members responsible to dispense medication shall review the possible side effects listed on the Drug Fact Sheet/Patient insert prior to initial dose of the medication.
b. Staff Members shall observe the reactions of the child to the medication and monitor the child's activity for a minimum of 30 minutes for adverse reactions to the medication.
c. If needed, provide parents with copy of Medication Dispensation Log with comments, so parent can take to doctor to communicate staff observations.
d. In the event of an adverse reaction, the staff member shall immediately notify the child's Healthcare Provider and the parent of the adverse reaction. Staff shall follow directions from the Healthcare provider. If the adverse reaction is severe, the staff member shall immediately notify emergency medical services.

Implementing written policies and procedures of the proper techniques for administering, handling and the storing of medication.

a. The staff members designated to dispense medication shall ensure that all policies regarding medication are followed and documented.
b. Staff shall wash all equipment used to dispense medication in hot water with dish soap and air dry after each use (separated from everything else).
c. Staff administering medication shall notify parents of the need for refills of medication when the supply of medication is 5 days doses prior to running out.
d. Staff shall properly dispose of expired, spoiled, or unused medication by returning it to the parent.
e. Herbal or Traditional Medication shall be not be administered at Head Start.

NAVAJO HEAD START
2013-2014 TRAINING PLANS
OVERALL AGENCIES

TOPICS	TRAINING OBJECTIVES	PERSON RESPONSIBLE	COMPLETION DATE	ESTIMITATED COST
Health Tracking Policies	Train and implement the revised policies and procedures along with forms to be utilized by all staff and parents to meet the 45-day mandate up to 90 days for follow-up of all health requirements.	Health/Nutri. Specialist	August 2014	$1,500.00 (Supplies, ink, copies, and mailing)
Height/Weight Intake and BMI reading	Attend training on height/weight intake and graphing along with BMI reading. (Hands On training)	Health/ Nutr. Specialist	August 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Vision Training and Certification	Attend training to receive certification for Vision screening and reading.	Health/Nutri. Specialist AZ Lions Vision	July 2014	$5,500.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Audio Training and Certification	Attend training to receive certification for Audio screening and reading. Calibrate audio	Health/Nutri. Specialist	July 2014	$5,000.00 (Supplies, printing, advertisement, Consultant Fee,

NAVAJO HEAD START
2013-2014 TRAINING PLANS
OVERALL AGENCIES

	machines on a yearly basis.			Calibration Fee, etc.)
Hematocrit/Hemoglobin, Blood Pressure, and Immunization, Reading and Certification	Attend training to receive certification for intake and reading of HCT/Hgb, Blood Pressure, and Immunization, of enrolled children	Health/Nutri. Specialist IHS Providers	July 2014	$1,500.00 (Supplies, printing, Consultant Fee, etc.)
Oral/Dental Health Screening Training	Attend training in Oral Health for proper screening of children.	Health/Nutri. Specialist IHS Providers	July 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Lead Screening and Reading Training	Attend Lead Screening training for reading purposes of lab results.	Health/Nutri. Specialist IHS Providers	July 2014	$1,500.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Health Fair, Screenings, and Health Check-up Days for enrolled children.	Conduct Health Fair within the community to implement screenings along with the Health Check-up Days at NNMC, DZlith Clinic, FCMC, and Tohatchi Health Clinic in order to meet the 45-day mandate, with follow-up	Health/Nutrition Spec.	Sept.- 45 Day Mandate Oct- 90- Day Mandate	$1,500.00 (Supplies, snacks, printing, advertisement, etc.)

NAVAJO HEAD START
2013-2014 TRAINING PLANS
OVERALL AGENCIES

	no later than 90 calendar days.			
Abuse/Neglect Conference	Gain knowledge and understanding the focal points of policies and procedures along with new implementations.	Health/Nutri.Specialist		$15,024.00 (Total) $350.00 x 06 staff = $2,100.00 (Registration) $169.00 x 06 staff =$1,014.00 x 5 nights =$5,070.00 (Lodging) $64.00 x 06 staff = $384.00 x 6 days = $2,304.00 (Meals) $800.00 x 06 staff = $4,800.00 (Flight Fare) $50.00 x 2 rental cars = $100.00 x 6 days = $600.00 (Rental) $25.00 x 6 days = $150.00 (Parking Fee)
Alchini Nizhoni Activities (Celebrating the Month of the Young Child)	Provide various activities for children in celebration of Alchini Nizhoni	Head Start Children Head Start Staff	April 2014	$5,000.00 (Rental Fee, Meals and Refreshments)
Health Wellness Day Activities for staff and Parents.	Provide physical activities for staff and parents inviting various resources to assist with activities.	Health/Nutrition Specialist Head Start Staff	April 2014	$4,000.00 (Rental Fee, Meals, and Refreshments)
CPR/1st Aide		NHS Staff	July/Aug. 2014	$40.00 x 06 staff =

NAVAJO HEAD START
2013-2014 TRAINING PLANS
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Certification	Attend a refresher training to meet required mandate.	Health/Nutri. Specialist		$240.00
Office of Environmental Health Trainings: ✓ Blood Borne Pathogens ✓ Infection Control ✓ Injury Prevention ✓ Medication Administration ✓ Recognizing Adverse Reaction to Medication ✓ Playground Safety ✓ MSDS ✓ Carbon Monoxide ✓ Lead Screenings ✓ Hand Washing ✓ Food Handlers Certification	Attend OEH mandated Trainings to be incompliance with the CFR45/Tribal Health Codes.	All Agency Staff All Central Staff Office Of Environmental Health Sanitarians	July/Aug. 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Fire Safety : ✓ Fire Protection ✓ Fire Suppression ✓ Fire Detection	Attend Fire Safety Mandated Trainings.	All Agency Staff All Central Staff Local Fire District Trainers	July/Aug. 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)

NAVAJO HEAD START
2013-2014 TRAINING PLANS
OVERALL AGENCIES

Model Health And Safety Code	Attend Model Health and Safety Code Training.	All Agency Staff All Central Staff OEH Sanitarians NNEnvironmental Health	July/Aug. 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Health Plans	Attend Health Plan Training.	All Agency Staff All Central Staff OEH Sanitarians	July/Aug. 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Emergency Management Training	Attend Emergency Management Training.	All Agency Staff Health & Nutrition Spec. & Liaisons NN Emergency Management Trainers	July/Aug. 2014	$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Native Family/Child Conference	Attendance Conference	Family Engagement Liaisons & Specs NHS Staff Health/Nutri. Spec. & Liaisons	Schedule	
National Health Training	Attend Training	NHS Parents Family Engagement Specialist & Liaisons Health/Nutri. Spec. & Liaisons		
Native American Responsible Father	Attend Conference	NHS Parents Family Engagement	June 14, 2014- January 8-10, 2014	$1,800.00 per person $1,800.00 per person

NAVAJO HEAD START
2013-2014 TRAINING PLANS
OVERALL AGENCIES

		Spec. & Liaisons Health/Nutri. Spec./Liaisons		
31st Native American Child Abuse/Neglect	Attend Conference	Family Engagement Spec. & Liaisons Health/Nutri.Specialist & Liaison	April 13-16, 2013	$510.00 per person
National Conference Disabilities	Attend Conference	Family Engagement Spec. & Liaisons Health Nutri. Specialist & Liaisons Disabilities Specialist	March 25-28, 2014	
Nutrition & Health Conference 2014	Attend Conference 2014 San Francisco, CA	Family Engagement Spec./Liaison Health & Nutrition Spec. & Liaison	Feb. 7- Apr. 20, 2014	$845.75 per person
41st Annual Head Start Conference 2014	Attend Conference 2014 Long Beach, CA	NHS Staff	April 28- May 2, 2014	
2nd International Conference on Nutrition and Growth (NEC 2014)	Attend Conference in Barcelona, Spain	NHS Staff Health & Nutrition Specialist/ Liaison Family Engagement Spec./ Liaison	Jan. 30- Feb. 1, 2014	
SNA Annual Conference 2014- School Nutrition	Attend Conference 2014 Boston, MA	NHS Staff Health & Nutrition	Jan. 21-22, 2014	

NAVAJO HEAD START
2013-2014 TRAINING PLANS
OVERALL AGENCIES

Association		Specialist/Liaisons Family Engagement Spec. & Liaisons		

NAVAJO HEAD START
2012-2013 HEALTH FLOW CHART

45/90 Day Mandate upon Enrollment for Center/Homebase/EHS sites

Table of Content
Parent Contact/Follow Up
Indian Health Service Consent Form
Child Health History
Health Screening Form (Vision, Audio, Dental, Screening)
Physical Examination (EPSDT/NHS)
Immunization Record (Updated annually)
Dental Information / Treatment form (6 months)
On-Site Dental Consent for Treatment
Growth Chart:
1st_____ 2nd_____
Date Date
Weight-for-Age/Length Percentiles (EHS only)
1st_____2nd_____3rd_____
Date Date Date
Weight-for-Stature Percentiles (EHS only)
1st_____2nd_____3rd_____
Date Date Date
Length for Age Percentiles (EHS only)
1st_____2nd_____3rd_____
Date Date Date
BRIGANCE:Self Help Social/Emotional
Scale/Behavorial Support Team
Patient Referral Notice (IHS)
Indian Health Service Authorization Disclosure Form
Allergies (Food, Medications, Animals, etc.)
Infant Feeding Preference (EHS only)
BRIGANCE: Developmental Screening

Teacher, Paraprofessional, FEL, H/NL,HN/C, NHSHSAC, DS, MHC.

Upon completion of all required Health Screenings and Examinations; a determination will be made if a referral is needed and to be forwarded to specified service providers.

On-going monitoring and follow ups of:
- Health Requirements
- Parent Contact/Letters
- Referral and Follow Ups

CENTRAL ADMINISTRATION

MONITOR/REPORT OVERALL HEALTH STATISTICS (CHILDPLUS)
- (5) Regions
- Analyze Tracking and Referral / Follow-up Logs NHSHSAC

HEALTH/NUTRITION SPECIALIST

REGION I - V

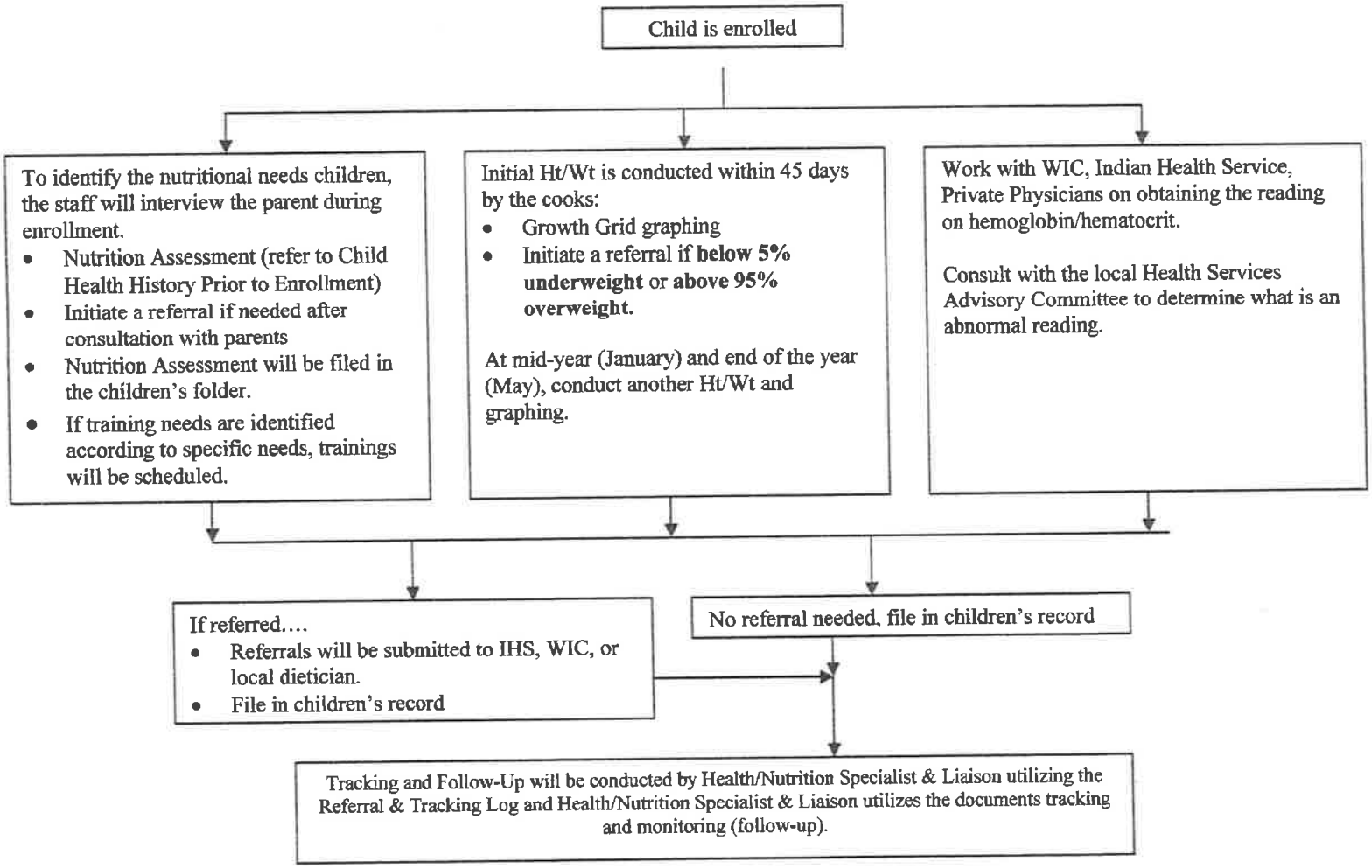
- Childplus Database
- Health Tracking
- Immunization Tracking
- Dental Tracking
- Ht/Wt/BMI. Tracking
- Referral and Follow-up Logs

Family Engagement Liaison & Health/Nutrition Liaison

COMPILATION OF HEALTH STATISTICS
- Service Areas
- Analyze Tracking and Referral / Follow-up Logs
- HSAC

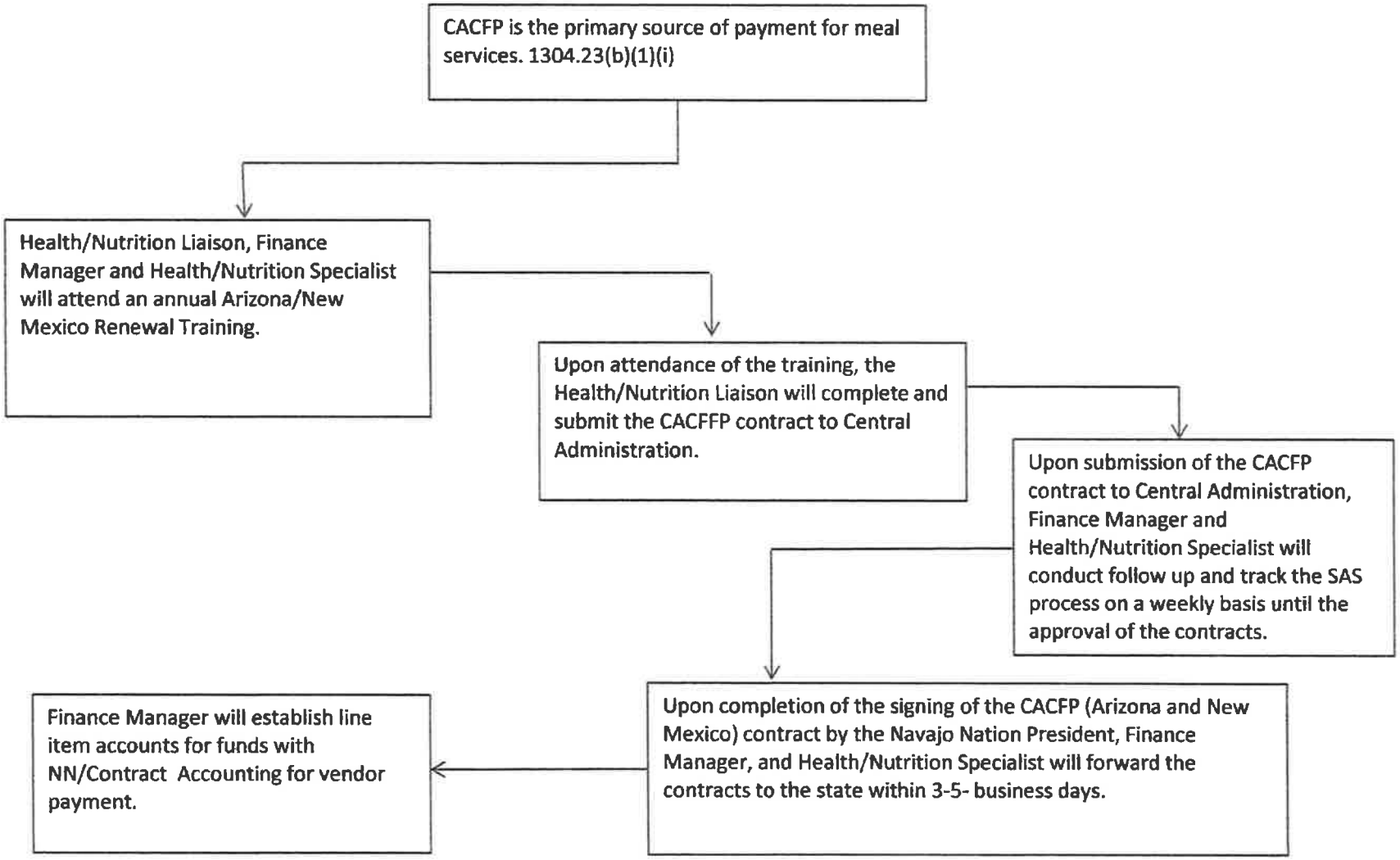
Health/Nutrition Specialist & Family Engagement Specialist

NAVAJO HEAD START
CHILD NUTRITION
FLOWCHART FOR CHILD NUTRITION ASSESSMENT



NAVAJO ' D START
CHILD NU RITION

FLOWCHART
Child and Adult Care Food Program (CACFP)
Contract Process



NAVAJO HEAD START

REGION (AGENCY):_____

INDIVIDUAL FOLLOW UP / ACTION STEP PLAN

CENTER: _____

CHILD'S NAME:	**DATE/TIME:**
COMMENTS: **STAFF NAME/DATE/TIME:**	
ACTION STEP 1: **STAFF NAME/DATE/TIME:**	
ACTION STEP 2: **STAFF NAME/DATE/TIME:**	
ACTION STEP 3: **STAFF NAME/DATE/TIME:**	

☐ INTAKE ☐ PENDING ☐ CLOSED

☐ HEALTH ☐ NUTRITION ☐ DISABILITY ☐ EDUCATION ☐ FPA ☐ MENTAL HEALTH

NOTE: THIS DOCUMENT SHALL BE KEPT IN CHILD'S FOLDER AT ALL TIMES.

DEFINITIONS

1. **HEALTH CARE:**
   Health care is the provision of health services of preventive, diagnostic, therapeutic and/or rehabilitative nature that do not involve major surgical procedures.
   The purpose of a medical examination is to appraise the child's health and physical condition. The medical examination consists of two parts. In the first part, questions are asked relative to the health present and past, of the child and his/her parents, in the second part a thorough examination is made of the child's body, including weight, height, blood pressure, vision, and hearing.

   Laboratory studies include tests of urine and blood.

   X-rays are taken when necessary to see if there is any abnormality within the body.

   A skin test consists of the injection into the skin of about a drop of a substance such as "tuberculin" or "coccidioidin." By means of these tests and x-rays of the chest, the physician determines whether the patient has or has had tuberculosis of valley fever.
2. **DENTAL CARE:**
   Dental care begins with the dental examination, which consists of (a) examining teeth, gums, tongue, and other parts of mouth with dental mirror and explores (probe) and (b) taking dental x-rays as needed.

   Routine dental care includes those services necessary to prevent the loss of teeth, such as cleaning the teeth, applying fluoride to the teeth, filling decayed teeth, and pulling teeth in order to prevent infection or clear up existing infection.

   Necessary emergency dental care consists of those services that cannot be deferred without endangering the child's health or life, such as the relief of pain, the clearing up of infection, and the control of bleeding.
3. **MENTAL HEALTH SERVICES:**
   Mental health services include psychological and psycho-educational testing, psychiatric evaluation, and consultation or assessment by mental health professionals. The information obtained is used to determine if it is appropriate or necessary to develop a treatment program for the child.
4. **EMERGENCY HEALTH CARE:**
   Emergency health care includes surgical and/or non-surgical procedures that cannot be deferred without endangering the child's health or life, surgical procedures that can be deferred are not authorized by the consent in this form. In such cases, the specific authorization for surgery from the parent or legal guardian is required.

PRIVACY ACT NOTICE TO PARENTS OR GUARDIANS

The Privacy Act of 1974 establishes procedures to protect information which the Federal government collects from individuals. It also requires that you be provided with the following information:

- Records of health care provided to your child are maintained by IHS under the following laws:
  - Public Health Service Act, Section 321;
  - Indian Self-Determination and Education Assistance Act;
  - Synder Act;
  - Indian Health Care Improvement Act;
  - Construction of Community Hospitals Act
  - Indian Health Service Transfer Act.
- IHS personnel will not reveal to anyone what is in your child's medical record without your written permission, except to:
  - Individuals or organizations who are authorized by an IHS medical staff member to provide health service to your child or to reimburse contractors for the services provided to him/her;
  - Federally approved organizations that evaluate the health care your child receives;
  - Persons performing health related research where IHS is assured the research will help native American people and the information will be adequately protected;
  - State or local governmental agencies when required by State or local law for purposes such as law enforcement and communicable disease control;
  - Local schools for the purpose of providing health care to the children they teach;
  - To the Bureau of Indian Affairs and their contractors for the identification of American Indian and Alaska Native handicapped children in support of P.L. 94-142, the Education for All Handicapped Children Act of 1975.
  - Organizations (Medicare/Medicaid, Insurance companies) for them to reimburse IHS and contract health service providers for services provided to your child;
  - Agencies acting on behalf of IHS to collect reimbursable payments or to make payments on behalf of the Indian Health Service.
- IHS employees are required to keep a list of people to whom they release information from your child's medical record. You have a right to see that list. The list must show what was release, to who m (name and address), for what purpose and the date of release. You may speak with personnel in the Medical Records Department to find out how to do this
- The information you provide will be maintained in Health and Medical Records System, HHs/PHS/HIS, (System Number 09-17-0019). The following are the reasons why Indian Health Service 9IHS) and contract health service providers need to collect information from and about your child (name, date of birth, mailing address, and past and present health information):
  - To find out how he/she feels or what they think is wrong;
  - To find out if a member of your family as a condition that could affect your child's health;
  - To locate their medical record among all the others;
  - To reach you and your family (for follow-up care, or to mail medical test results or future appointments to you) to maintain your child's health;
  - To determine your child's health condition and the kind of care that is right for him/her.
- It is not necessary to answer these questions to receive medical care. However, if you give complete and correct information to the best of your ability, then HIS and contract health service staff will be better able to deciede what the proper care is that your child needs. If you have any questions about this form or your child's health record, you may ask an Indian Health Service doctor or nurse to explain it o you. Thank you for your help.

PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON1 WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

Name of Student:_____ **Birth Date:**_____

(We),_____

have read the Consent Form for the Indian Health to arrange for or to provide the following health services for this child:

Health care including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.

Dental care including dental examinations, preventive use of fluorides and necessary emergency dental care.

Mental health services including evaluation and treatment as necessary.

Emergency health care for accidents or illness.

Transportation of the child to and/or from another health facility for these services.

☐ **I hereby give consent for all of the above services.**

☐ **Exceptions or Special Instructions.** _____

_____

_____

Signed:_____

Address:_____

Relationship:_____

Date:_____ Valid until:_____

PLEASE RETURN THIS FORM TO THE SCHOOL

Note: 1 Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

IHS-810 (4/09)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 1/31/2013
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other *(Specify)* _____

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is:
(1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

PSC Graphics (301) 443-1090 EF

IHS-810 (4/09)
BACK

Instructions for Completing IHS Form 810 --
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.

5. Section IV, check the appropriate box as applicable.

   a. **Only information related to** -- specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

   c. **Other *(specify)*** – e.g., CHS, Billing, Employee Health.

   d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6. Section V, if a different *expiration* date is desired, specify a new date.

7. Section V, Please sign (or mark) and date.

8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

Navajo Head Start/Early Head Start
Prenatal Health/Nutrition History

Name:	Today's Date:
Expected Due Date::	
How far along are you in your pregnancy?	
Do you have health insurance?	

Prenatal Care:

Is this considered a high risk pregnancy? Explain:	
Are you already receiving prenatal care?	
Date of first prenatal visit?	Date of most recent visit?
Date of next scheduled visit?	
Name of provider:	*Provider type:*
Address:	
Phone Number:	

Dental:

Date of last dental exam:	
Do you have dental insurance? Yes/No	Medicaid, private, or other?
Name of provider:	*Provider type:*
Address:	
Phone Number:	

Health History:

What complications have you experienced with this pregnancy or a previous one?

Please circle any that apply:

headaches	high blood pressure	Irritability	Anxiety/stress
Diabetes	Low birth weight baby	Pre-term labor	Premature birth<35 weeks
Neonatal death	C-section	Swelling	Fatigue
Bleeding	anemia		

Please add any additional comments regarding above complications?

Has this or a previous pregnancy required bed rest or hospitalization? For how long?

If not your first pregnancy, how long has it been since your last pregnancy?

Have you used any of the following during your pregnancy? Please circle all that apply:
Caffeine Cigarettes/tobacco Over the counter medication/prescription drugs
Alcohol Other drugs: please specify

Do you have any mental health concerns such as depression?

Are you receiving services for mental health or substance abuse? If yes, with what agency?

Navajo Head Start/Early Head Start
Prenatal Health/Nutrition History

Prenatal Nutrition History
Are you receiving services from WIC?
Do you plan to breast feed your baby?
Do you take prenatal vitamins?
Do you have any questions or concerns about breast feeding?
Do you eat 4 or more servings of milk products a day? This can be milk or milk products, yogurt, cottage cheese, or hard cheese, tofu with extra servings of almonds, nuts, and kale.
Do you eat at least 3 or more servings of protein a day? Meat, poultry, fish, eggs or nuts are sources of protein.
Do you eat a source of folic acid daily? Choose at least one good source of folic acid every day, like dark green leafy vegetables, veal, and legumes (lima beans, black beans, black-eyed peas and chickpeas). Every pregnant woman needs at least 0.4 mg of folic acid per day to help prevent neural tube defects such as spina bifida.
Do you eat a serving of Vitamin A daily? Choose at least one source of vitamin A every other day. Sources of vitamin A include carrots, pumpkins, sweet potatoes, spinach, water squash, turnip greens, beet greens, apricots, and cantaloupe. Know that excessive vitamin A intake (>10,000 IU/day) may be associated with fetal malformations.
Do you eat a source of Vitamin C every day? Choose at least one good source of vitamin C every day, such as oranges, grapefruits, strawberries, honeydew, papaya, broccoli, cauliflower, Brussels sprouts, green peppers, tomatoes, and mustard greens. Pregnant women need 70 mg of vitamin C a day.
Do you have 6-11 servings of breads/grains daily?
Do you have 2-4 servings of fruit daily? Do you have 4 or more servings of vegetables daily?
Do you have any concerns about your diet?

Enrollment Signatures	
Mother:	Date:
Staff:	Date:

Navajo Head Start/Early Head Start
Prenatal Health/Nutrition History

INSTRUCTIONS

WHO

1. **The form is for Pregnant Program ONLY.**
2. This is to be completed for Pregnant women and concludes with a signature on page 3.
3. A Navajo Head Start staff will interview the enrolled pregnant woman.

HOW

When interviewing the participant make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If they need resources or well child checkup; provide them with resources, pamphlets, hospitals. Fully complete the following sections:

1. Prenatal Care
2. Dental
3. Health History
4. Prenatal Nutrition History
5. Enrollment Signature

APPENDIX B

EPSDT STANDARDS AND TRACKING FORMS

AHCCCS

AHCCCS EPSDT TRACKING FORMS

The AHCCCS EPSDT Tracking Forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; paper form substitutes are not acceptable. If Provider chooses to utilize an electronic EPSDT form, this electronic substitute will be acceptable provided the following conditions are met:

1. Provider's electronic form includes all fields that are present on the AHCCCS EPSDT form.

2. In the future AHCCCS may create an electronic EPSDT form. In that event, provider agrees to convert to AHCCCS electronic EPSDT form.

AHCCCS Contractors are required to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Contractor EPSDT Coordinator) and to distribute these forms to their contracted providers. Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

A copy of the completed form signed by the clinician should be placed in the member's medical record.

If the member is enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.

If the patient is an AHCCCS fee-for-service member [e.g., enrolled in the American Indian Health Program (AIHP)], the provider should maintain a copy of the EPSDT tracking form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce the EPSDT forms as needed. All others may reproduce the forms with permission of the Arizona Health Care Cost Containment System. Written requests for the Tracking Forms may be directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6500
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. ***Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.***

Contact information for AHCCCS' subcontracted health care plans may be found at www.ahcccs.state.az.us.

Revised: 10/01/2009, 07/01/2001, 11/01/2007, 01/01/2004, 11/01/2003, 06/01/2003

2 through 4 Days Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast feeding ☐ Formula: _____
☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Rooting reflex ☐ Startle ☐ Suck & swallow ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Passive smoke ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Guns ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Encourage holding ☐ Infant hands to mouth/self calming ☐ Other

COMPREHNSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ 2nd Newborn screening (5 – 10 days of age or first PCP visit) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today
☐ Shot record initiated ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/ DDD ☐ Developmental
☐ Behavioral ☐ Specialty ☐ Early Head Start ☐ 2nd Newborn hearing screening **(if needed)** ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

1 Month Old **AHCCCS EPSDT Tracking Form**

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE; **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about the baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Responds to sounds ☐ Responds to parent's voice ☐ Follows with eyes ☐ Awake for 1 hour stretches ☐ Beginning Tummy Time Play ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ 2nd Newborn screening (5 – 10 days of age or first PCP visit) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today ☐ Shot record initiated ☐ 2nd Hepatitis B vaccine date: _____ ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ 2nd Newborn hearing screen (if needed) ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐ Yes ☐ No

2 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Risk indicators of hearing loss: ☐ yes ☐ no
Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Some Head Control ☐ Coos, babbles ☐ Makes Eye Contact ☐ Fixes/follows with eyes ☐ Begins imitation of movement and facial expressions ☐ Tummy Time/ lifts head, neck with forearm support ☐ Startles at loud noises ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Pacifiers ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Social smile ☐ Enjoys interacting with others ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ 2nd Newborn screening (if needed) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

4 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:			Temp:	Pulse:	Resp:
Risk indicators of hearing loss: ☐ yes ☐ no	Medications:		Wt:	%	Length:	%	Head circ:	%	

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: ☐ Cereal ☐ Plan to introduce solids ☐ Soda/Juice ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS ☐ Babbles and coos ☐ ☐ Smiles ☐ Begins to roll front to back ☐ Pushes up with arms ☐ Controls head well ☐ Reaches for objects ☐ Interest in mirror images ☐ Pushes down with legs when feet on surface ☐ Looks at you with eyes ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Car seat/rear facing ☐ Emergency 911 ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Establish daily routines/infant regulation ☐ Establish nighttime sleep routine/sleep through night=5 hours ☐ Introduce child temperament/easy/sensitive ☐ Passive smoke ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/Parent responds positively to baby ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Smiles when hears parents' voice ☐ Encourage holding ☐ Easily distracted/excitement of discovery of outside world ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Early Head Start ☐ Behavioral ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

6 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____ ☐ Rice cereal ☐ Solids ☐ Soda/Juice ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ "Dada, baba" babbles ☐ Rolls over ☐ Transfers small objects ☐ Vocal imitation ☐ Sits with support ☐ Explores with hands and mouth ☐ Peek-a-boo/patty cake ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Introduce board books/mouthing ☐ Introduce cup ☐ Passive smoke ☐ Teething/tooth brushing ☐ Sleep/wake cycle ☐ Parent reads to child ☐ Refrain from jump seat/walker ☐ Begin using high chair ☐ Other

BEHAVIORAL HEALTH SCREEN:: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family Adjustment/parent responds positively to baby ☐ Encourage holding ☐ Self calming ☐ Wary of strangers ☐ Recognizes familiar people ☐ Distinguishes emotions by tone of voice ☐ Enjoys social play ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐Influenza ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

9 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: ☐ yes ☐ no	Medications:		Wt: %	Length: %		Head circ: %	

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

ORAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing teeth ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____ ☐ Soda/Juice ☐ Solids ☐ Supplements:

DEVELOPMENTAL SCREEN: ☐ Goes from sitting to all fours ☐ Peek-a-boo ☐ Uses words such as "mama/dada" ☐ Sits independently ☐ Repeats sounds/gestures for attention ☐ Explores environment ☐ Waves bye-bye ☐ Drinks from cup ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun Safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Sleep/wake cycle ☐ Wary of strangers ☐ Introduce board books ☐ Soft texture finger foods/choking ☐ Redirection/positive parenting ☐ Exploration/learning ☐ Passive smoke ☐ Language/read to child ☐ Follow child's lead in play ☐ Parent communicates to child "what things are"(ball, cat etc) ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Growing Independence ☐ Shows preference for certain people/toys ☐ Cries when primary care giver leaves ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct (perform at 9 months) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

12 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Daily tooth brushing ☐ First dental appointment White spots on teeth ☐ yes ☐ no

NUTRITIONAL SCREEN:: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula:_____

☐ Adequate intake Solids: _____

☐ Supplements_____ ☐ Soda ☐ Juice

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ First steps ☐ "Mama" "dada" specific ☐ Uses single words ☐ Scribbles ☐ Precise pincer grasp ☐ Follows simple one step requests ☐ Looks for hidden objects ☐ Extends arm/leg for dressing ☐ Point to/label pictures ☐ Plays: hides object/pushes ball back and forth ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Passive smoke ☐ Car seat safety/20#'s AND 1 year = forward facing ☐ Weaning plan/milk intake ☐ Discipline/praise ☐ Follow child's lead in play ☐ Ignore tantrums/give attention to positive behaviors ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Prefers primary care giver over all others ☐ Shy/anxious with strangers

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine (scoliosis)		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP:

LABS ORDERED: [X] INDICATES ORDERED ☐ Blood Lead Test (perform at 12 months) ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ Hep A ☐ HepB ☐ MMR ☐ Varicella ☐ DtaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature

See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

15 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes a blood lead test is required)

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Feeds self ☐ Breast fed/whole milk ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Says 3-6 words ☐ Says No ☐ Wide range of emotions ☐ Repeats words from conversation ☐ Knows one color ☐ Understands simple commands ☐ Climbs stairs ☐ Walking ☐ Puts objects in container and takes object out of container ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Car seat safety/40#'s/4 years ☐ Gentle limit setting/redirection/safety ☐ Reading/parent asks child "what's that?" ☐ Manage growing independence/defiant behavior ☐ Follow child's lead in play ☐ Offer opportunity to scribble/explore ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Social interaction/eye contact/comforts others ☐ Begins to have definite preferences ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ TB skin test (if at risk)

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

18 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: ☒ INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Breast fed/whole milk ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS ☐ Uses a cup ☐ Walks ☐ Says 10-20 words ☐ Says "No" ☐ Name one picture/2 colors/ ☐ Follows simple rules/bring me the book ☐ Knows animal sounds ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Discipline/limits ☐ Read to child ☐ Dental caries prevention ☐ Sibling interaction ☐ Nutrition/mealtimes ☐ Defiant behavior/offer child choices ☐ Never leave toddler alone ☐ Growing independence ☐ Encourage expression of wide range of emotions ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Demonstrates increasing independence ☐ Begins to show defiant behavior ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ TB skin test (if at risk) Other ☐

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

24 Months Old **AHCCCS EPSDT Tracking Form**

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Ht:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing (by parent) ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: ☐ Kicks a ball ☐ stacks 5-6 blocks ☐ 20 word vocabulary ☐ Walks up stairs/runs well ☐ Communicates needs in 2-4 word sentences ☐ Names 6 body parts Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sleep practices ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirection/praise ☐ read to child ☐ Car safety/booster seat/5 pt harness ☐ Learns 5-6 words every week ☐ Provide opportunities for success/choice: 2 items "juice or milk"/"red or blue shirt" ☐ Praise for effort/success ☐ Establish daily routine ☐ Encourage/support wide range of emotions ☐ Trike/bike safety ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Sense of humor ☐ Demonstrates increasing independence ☐ Plays alongside peers ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Blood Lead test (perform at 24 months) ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

3 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing (by parent) daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Uses imaginary characters ☐ Matches colors and shapes ☐ Counts to 5 ☐ Names self and others ☐ Knows gender ☐ Begins to play: games with simple rules/interactive games ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE:: [X] INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for: bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ "Monster" fear ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Has words for feelings ☐ Separates easily from parent ☐ Objects to major change in routine ☐ Shows interest in other children ☐ Feels competent ☐ Kind to animals ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Blood Lead Test (perform at 36 – 72 months if not already done) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent Refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

4 Years Old **AHCCCS EPSDT Tracking Form**

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam			Allergies:				Temp:	Pulse:	Resp:	B/P
			OD	OS	OU								
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:			
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform										
Speech: age appropriate ☐ yes ☐ no		Medications:											

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing (by parent) daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Sings a song ☐ Draws a person with 3 parts ☐ Gives first/last name ☐ Names 6-8 colors/3 shapes ☐ Counts 1-7 objects out loud (not always in order) ☐ Names self and others ☐ Shows interest in other children ☐ Plays interactive with simple rules ☐ Asks/answers who, what, where, why ☐ Follows 2 unrelated directions ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Separates easily from parent ☐ Feels competent ☐ Kind to animals ☐ Objects to major change in routine ☐ Has words for feelings ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test (perform at 36 – 72 months if not already done)

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ Influenza ☐ PCV ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

5 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN :[X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN:[X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Recognizes most letters/shapes/numbers to 10 ☐ Recognize/identify some letters and phonic sounds ☐ Sorts and counts up to 5 objects ☐ Holds pencil ☐ Cuts with scissors ☐ Cooperates more in group setting ☐ Runs/skips/jumps ☐ Begins to agree with rules ☐ Can button and zip clothing independntly ☐ Goes to bathroom independently ☐ Likes to sing/dance/act ☐ Knows address ☐ Plays board games ☐ Dictates story to adults ☐ Listens to authority figure and follows instructions ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE:[X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Set only 3-5 rules for your child ☐ Car seat <40 lbs/belt positioning booster seat <4'9''/air bags ☐ Other

BEHAVIORAL HEALTH SCREEN:[X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Shows empathy for others ☐ Wants to please & be with friends ☐ Positive about self & abilities ☐ Tells stories of convenience(lying) ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis **(to be completed at 5 years)** ☐ TB skin test **(if at risk)** ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] INDICATESORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

6 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam		
			OD	OS	OU
Audiometry			Corrected ☐ yes ☐ no		
☐ WNL	☐ Abnormal				
Speech: age appropriate ☐ yes ☐ no		Medications:			

Allergies:	Temp:	Pulse:	Resp:	B/P

Wt:	%	BMI:	%	Ht:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Language is expressive and understandable ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Provide opportunities for social interaction/invite friends over to play board games/dress up etc. ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Frustration/impulse control ☐ Communication/language ☐ Has friends ☐ Plays well with others/by self ☐ Is liked by other children ☐ Feels capable ☐ Expresses full range of emotions ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

7 – 8 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P

Audiometry		Vision Chart Exam			Wt:	%	BMI:	%	Ht:	%
☐ WNL	☐ Abnormal	Corrected ☐ yes ☐ no								
Speech: age appropriate ☐ yes ☐ no		Medications:								

PARENTAL/PATIENT CONCERNS/HISTORY:

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Bullying ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family adjustment/parent responds positively to child ☐ Frustration /impulse control ☐ Communication/language ☐ Comfortable body image ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hep A ☐ MMR ☐ Varicella ☐ Td ☐ Influenza ☐ Hep B ☐ IPV ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

9 – 12 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses		Allergies:		B/P:	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

PARENTAL/PATIENT CONCERNS:

HEALTH RISK ASSESSMENT: ☐ Early Adolescent GAPS (begin at 10 years) ☐ Other

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: Early adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STI ☐ Peer refusal skills ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Risks of tattoos/ piercing ☐ After school activities/supervision Bullying ☐ Self control ☐ Other

Behavioral Health Screen: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ Lipid Profile TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Tdap (11 - 12years only) ☐ Meningococcal (11 – 12 years only) ☐ HPV (11 – 12 years) ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Td ☐ Influenza ☐ IPV ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

13 – 17 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Parent/Patient Concerns/History:

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: Middle Adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Risk taking (Learning to drive 15 to 17 years) ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Bullying ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Sexual orientation/dating ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ After school activities/supervision ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN & FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ U/A **(preferred at 16 yrs)** ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

18 – 21 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Patient Concerns/History:

HEALTH RISK ASSESSMENT: [X] INDICATES ASSESSMENT USED: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: Late Adolescence: ☐ Abstract thinking ☐ School attendance ☐ Sexuality/orientation ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Athletic activities ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction/dating ☐ Parenting advice (as appropriate) ☐ Future oriented ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ Job/career planning ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Philosophical/idealistic ☐ Comfortable body image ☐ Building intimate, complex relationships ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ OB/Gyn ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

Child's Name:	Male/female
Date of Birth:	

Birth Information:			
Type of Deliver: Vaginal or C-section	Birth Weight:	Birth Length:	
Where was your child born?			
Where there any concerns with mom or baby during the pregnancy or delivery?			
Was your baby born earlier or later than expected?			
Was there use of drugs/alcohol/tobacco/caffeine during the pregnancy?			

Developmental History

Most of the time	Some-times	Rarely	Never	
				Does your child arch/stiffen when picked up?
				Does your child make eye contact when being fed/held?
				Do you have concerns about your child's sleep pattern?
				Does your child look at objects and follow them with her/his eyes?
				Does your child make sounds or babble?
				Does your child respond to your voice by looking at you?
				Does your child have different cries when he/she is upset, uncomfortable or happy?
				Does your baby hold her/his head steady when being held?
				Do you have any concerns about your child's development?

Does your child sleep on his/her (Please circle: stomach back side)?

How do you put your child to sleep?

Medication* **May require Medication Administration forms to be completed.**

Yes	No	
		Does your child take medication on a regular basis? If yes, what:
		Will your child need this medication while at Early Head Start?*
		Does your child have medication for emergency use?* If yes, what?

Dental

Yes	No	
		Does your child have any teeth yet?
		Do you clean your child's teeth/gums?
		Do you have any concerns about your child's teeth?
		Does your child take a fluoride supplement? (6 months and older)

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

Child Health Information: * May indicate need for health care plan.			
Yes	*No*	*Condition*	*If yes, please describe:*
		Allergy other than food*	
		Asthma/breathing concern*	
		Cerebral Palsy*	
		Colic	
		Constipation	
		Diabetes*	
		Diarrhea	
		Frequent earaches/infections	
		Eczema	
		Lead exposure	
		Tuberculosis exposure	
		Fetal alcohol	
		Heart Condition*	
		Low Birth Weight	
		Seizures*	
		Sickle cell	
		Yellow Jaundice	
		Other	
		Surgery	

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

Feeding/Nutrition * May require a health care plan.		
Yes	No	
		Does your child have any **known food allergies?*** If yes, to what food? What happens when child had that food?
		Do you breast feed your baby? How often? How many times in 24 hours?
		Does your child drink from a bottle? How often? How many times in 24 hours? What kind of bottle/nipple do you use?
		Do you feed your child formula? If yes, what brand?
		Has your child been diagnosed with reflux* Did she/he receive treatment? How is the baby doing now?
		Does your child take a vitamin supplement, iron supplement? Please list what kind and for how long:
		Does your baby drink a bottle in bed?
		Has your child been diagnosed with anemia?
		Do you give your child milk? If yes, what kind?
		Do you have any questions or concerns about what/how your baby eats or his/her growth? If yes, what:
		Is your child on WIC? If yes, where:
Which of these food do you offer your child: (Please circle) Eggs Poultry Vegetables Bread Fruit Meat Cereal Rice Juice Please specify which vegetables, fruits, cereal you have offered your child:		

Enrollment Signatures	
Parent:	Date:
Staff:	Date:
Second Year Signatures: Second year, please review information and record any changes with date and initials.	
Parent:	*Date:*
Staff:	*Date:*

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

INSTRUCTIONS

WHO

1. **The form is for children ages BIRTH to 1 year of age ONLY.**
2. This is to be completed for new enrollees and concludes with a signature on page 3.
3. For second year children, have parents review and record any changes with date, and initials and have them sign on page 3
4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

1. Personal/Birth Information: The first portion will consist of name, birth, and labor.
2. Child Health Information: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child may need health plan completed.
3. Behavioral Information: If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
4. Nutrition Information: If there are any concerns please include in this section and child may need health plan for any known allergies.
5. Allergies/Medications: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
6. Ensure that all signatures and date are completed.

Navajo Head Start/Early Head Start
Health/Nutrition History

(Ages 1 Year-5 Years)

Child's Name: Date of Birth: Male/female	
Birth Information:	
Birth Weight:	Birth Length:
Was your baby born early or late? How early?	
Were there complications during pregnancy or birth? If yes, please describe:	

Does your child have any of the following:			
Yes	No	Health Concern	If yes, please describe:
		Anemia	
		Asthma/breathing problems*	
		Bowel/bladder problems	
		Diabetes*	
		Frequent ear ache/ infections/hearing concerns?	
		Heart condition*	
		Frequent nose bleeds	
		Seizures*	
		Skin Condition	
		Tuberculosis exposure	
		Walking/climbing difficulties	
		Vision concerns/wears glasses	Date of last exam if done:
		Tested for lead?	Date & results:
		Any other concerns? Or any concerns about your child's teeth?	
		Has your child had a serious illness, injury, hospitalization or is being seen by a specialist?	

**Indicates child should have health care plan completed.*

Behavioral Information
Do you have concerns about your child's development or behavior? If yes*, please describe below:

**A referral to mental health services may be required.*

Navajo Head Start/Early Head Start
Health/Nutrition History

Nutrition Information		
Yes	No	Please answer the following:
		Is your child on WIC?
		Do you have any questions about feeding your child? If yes, please explain:
		Are you satisfied with what your child eats? How many meals _____ and snacks_____ are offered? If no, please explain:
		Do you share meals together as a family?
		Does your child drink from a cup?
		Is your child currently breast feeding?
		Do you have any concerns about your child's height or weight or growth?
		Does your child take a vitamin? With fluoride? Does your child take a supplement with iron? Why and how often?
		Does your child currently use any nutritional supplements (pediasure, ensure, herbs, etc)? If yes, how often and for what reason?
		Does your child eat non-food items? Please list:

Medications		
Yes	No	
		Does your child take any medication? Please list, including vitamins:
		*Will your child need to take any medication during preschool hours?
		*If medication is required during school hours, please review Medication Policy with parent and assist to completed necessary paperwork.

Navajo Head Start/Early Head Start

Health/Nutrition History

Allergies
Does your child have any allergies or severe reactions to any of the following? Please circle all that apply, if *other please explain.* **Insect bites/bee stings** **Animals** **Pollens/hay fever** **Medications** **Food** **Other**
Please describe your child's reaction?
How do you treat your child's allergy?
Has the allergy been diagnosed by a doctor?
Does your child have an Epi-pen prescribed?
If your child has a food or milk allergy, we will ask you for documentation from your medical provider that includes a list of foods that can be substituted. *If your child's allergy is severe and an Epi-pen or other medicine is prescribed we will ask you to obtain Medication Administration paperwork and other care plan information from your medical provider.*

Enrollment Signatures	
Parent:	Date:
Staff:	Date:

Second Year Signatures: Second year, please review information and record any changes with date and initials.	
Parent:	Date:
Staff:	Date:

Navajo Head Start/Early Head Start
Health/Nutrition History

INSTRUCTIONS

WHO

1. The form is for children ages 1 year to 5 years of age ONLY.
2. This is to be completed for new enrollees and concludes with a signature on page 3.
3. For second year children, have parents review and record any changes with date, and initials and have them sign on page 3
4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

1. Personal Information: The first portion will consist of name, birth, and labor.
2. Health History: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child should have health plan completed.
3. Behavioral Information: If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
4. Nutrition Information: If there are any concerns please include in this section.
5. Allergies/Medications: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
6. Ensure that all signatures and date are completed.

NAVAJO HEAD START
VISION, HEARING, DENTAL SCREENING

Language Used:
Navajo/English/Other: _____

Center/Homebase: _____

Child's Name: _____ DOB: _____ Age: _____ Gender: _____

VISION SCREENING

	Visual Acuity					
	Right	Left	Pass	Fail	Date	Screener
1st Screening						
Rescreen						

NOTE: If not completed on PE (includes-EPSDT) a screening will be conducted by Head Start staff.

	Stereopsis			
	Pass	Fail	Date	Screener
1st Screening				
Rescreen				

Referred to: _____ Date: _____

HEARING SCREENING:

Date: _____ Screener: _____ Date of Rescreen: _____ Screener: _____

	500 Hz @ 25 db	1000 Hz @ 20 db	2000 Hz @ 20 db	4000 Hz @ 20 db
Right				
Left				

Results: Pass: _____ Fail: _____

	500 Hz @ 25 db	1000 Hz @ 20 db	2000 Hz @ 20 db	4000 Hz @ 20 db
Right				
Left				

Results: Pass: _____ Fail: _____

NOTE: If not completed on PE (includes -EPSDT) a screening will be conducted by Head Start staff.

Visual Observation: _____

Referred to: _____ Date: _____

DENTAL SCREENING: A screening is not the same as a dental exam. In a screening you are only prioritizing the need for the child to see a dentist. The dentist is the person who initiates the dental examination and treatment.

BBTD: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Referred to: _____ Referred by: _____ Date: _____

Priority 1 **EMERGENCY CARE:** Children with dental problems needing immediate care because of pain or conditions that may or soon or is already effecting the child's general health. (Trauma, Pain, Swelling - face/mouth, Abscesses, Infections)

These children should be referred for dental services immediately.

Priority 2 **ROUTINE CARE:** Children with dental problems that need treatment but which do not at the time of the screening, pose a serious general health problem. (obvious cavities, no pain, no swelling or no abscesses).

These children should be referred to dental clinic for routine examination.

Priority 3 **EXAMINATION:** Children with no obvious dental problems that will effect general health. These children will still need to have a dental examination done by a dentist. (No obvious cavities, no pain, no swelling or no abscesses).

These children should be seen by a dentist for an examination.

Applied Fluoride Varnish

Date: _____ Date: _____ Date: _____

By: _____ By: _____ By: _____

Height & Weight (EHS Four Times & HS Two Times)

EHS: Ht:____ Wt:____ Head Circum:____ Date:_____

Ht:____ Wt:____ Head Circum:____ Date:_____

Ht:____ Wt:____ Head Circum:____ Date:_____

Ht:____ Wt:____ Head Circum:____ Date:_____

HS: Ht:____ Wt:____ BMI:____ Date:_____

Ht: ____Wt:____ BMI:____ Date:_____

Revised: 7/31/2012

2 through 4 Days Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast feeding ☐ Formula: _____
☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Rooting reflex ☐ Startle ☐ Suck & swallow ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Passive smoke ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Guns ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Encourage holding ☐ Infant hands to mouth/self calming ☐ Other

COMPREHNSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ 2nd Newborn screening (5 – 10 days of age or first PCP visit) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today
☐ Shot record initiated ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Specialty ☐ Early Head Start ☐ 2nd Newborn hearing screening **(if needed)** ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

1 Month Old **AHCCCS EPSDT Tracking Form**

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE; **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about the baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Responds to sounds ☐ Responds to parent's voice ☐ Follows with eyes ☐ Awake for 1 hour stretches ☐ Beginning Tummy Time Play ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ 2nd Newborn screening (5 – 10 days of age or first PCP visit) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today ☐ Shot record initiated ☐ 2nd Hepatitis B vaccine date: _____ ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ 2nd Newborn hearing screen (if needed) ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐ Yes ☐ No

2 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Risk indicators of hearing loss: ☐ yes ☐ no
Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Some Head Control ☐ Coos, babbles ☐ Makes Eye Contact ☐ Fixes/follows with eyes ☐ Begins imitation of movement and facial expressions ☐ Tummy Time/ lifts head, neck with forearm support ☐ Startles at loud noises ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Pacifiers ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Social smile ☐ Enjoys interacting with others ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ 2nd Newborn screening (if needed) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

4 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: ☐ yes ☐ no	Medications:		Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: ☐ Cereal ☐ Plan to introduce solids ☐ Soda/Juice ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS ☐ Babbles and coos ☐ ☐ Smiles ☐ Begins to roll front to back ☐ Pushes up with arms ☐ Controls head well ☐ Reaches for objects ☐ Interest in mirror images ☐ Pushes down with legs when feet on surface ☐ Looks at you with eyes ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Car seat/rear facing ☐ Emergency 911 ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Establish daily routines/infant regulation ☐ Establish nighttime sleep routine/sleep through night=5 hours ☐ Introduce child temperament/easy/sensitive ☐ Passive smoke ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/Parent responds positively to baby ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Smiles when hears parents' voice ☐ Encourage holding ☐ Easily distracted/excitement of discovery of outside world ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Early Head Start ☐ Behavioral ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

6 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____
☐ Rice cereal ☐ Solids ☐ Soda/Juice ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ "Dada, baba" babbles ☐ Rolls over ☐ Transfers small objects ☐ Vocal imitation ☐ Sits with support ☐ Explores with hands and mouth ☐ Peek-a-boo/patty cake ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Introduce board books/mouthing ☐ Introduce cup ☐ Passive smoke ☐ Teething/tooth brushing ☐ Sleep/wake cycle ☐ Parent reads to child ☐ Refrain from jump seat/walker ☐ Begin using high chair ☐ Other

BEHAVIORAL HEALTH SCREEN:: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family Adjustment/parent responds positively to baby ☐ Encourage holding ☐ Self calming ☐ Wary of strangers ☐ Recognizes familiar people ☐ Distinguishes emotions by tone of voice ☐ Enjoys social play ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

9 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: ☐ yes ☐ no	Medications:		Wt: %	Length: %	Head circ: %		

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: ☒ INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

ORAL SCREENING: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing teeth ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____ ☐ Soda/Juice ☐ Solids ☐ Supplements:

DEVELOPMENTAL SCREEN: ☐ Goes from sitting to all fours ☐ Peek-a-boo ☐ Uses words such as "mama/dada" ☐ Sits independently ☐ Repeats sounds/gestures for attention ☐ Explores environment ☐ Waves bye-bye ☐ Drinks from cup ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun Safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Sleep/wake cycle ☐ Wary of strangers ☐ Introduce board books ☐ Soft texture finger foods/choking ☐ Redirection/positive parenting ☐ Exploration/learning ☐ Passive smoke ☐ Language/read to child ☐ Follow child's lead in play ☐ Parent communicates to child "what things are"(ball, cat etc) ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Growing Independence ☐ Shows preference for certain people/toys ☐ Cries when primary care giver leaves ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct (perform at 9 months) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

12 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:
Risk indicators of hearing loss: ☐ yes ☐ no	Medications:		Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Daily tooth brushing ☐ First dental appointment White spots on teeth ☐ yes ☐ no

NUTRITIONAL SCREEN:: ☒ INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula:_____

☐ Adequate intake Solids: _____

☐ Supplements_____ ☐ Soda ☐ Juice

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: ☐ First steps ☐ "Mama" "dada" specific ☐ Uses single words ☐ Scribbles ☐ Precise pincer grasp ☐ Follows simple one step requests ☐ Looks for hidden objects ☐ Extends arm/leg for dressing ☐ Point to/label pictures ☐ Plays: hides object/pushes ball back and forth ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Passive smoke ☐ Car seat safety/20#'s AND 1 year = forward facing ☐ Weaning plan/milk intake ☐ Discipline/praise ☐ Follow child's lead in play ☐ Ignore tantrums/give attention to positive behaviors ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Prefers primary care giver over all others ☐ Shy/anxious with strangers

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine (scoliosis)		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP:

LABS ORDERED: ☒ INDICATES ORDERED ☐ Blood Lead Test (perform at 12 months) ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ Hep A ☐ HepB ☐ MMR ☐ Varicella ☐ DtaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature

See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

15 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes a blood lead test is required)

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Feeds self ☐ Breast fed/whole milk ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Says 3-6 words ☐ Says No ☐ Wide range of emotions ☐ Repeats words from conversation ☐ Knows one color ☐ Understands simple commands ☐ Climbs stairs ☐ Walking ☐ Puts objects in container and takes object out of container ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Car seat safety/40#'s/4 years ☐ Gentle limit setting/redirection/safety ☐ Reading/parent asks child "what's that?" ☐ Manage growing independence/defiant behavior ☐ Follow child's lead in play ☐ Offer opportunity to scribble/explore ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Social interaction/eye contact/comforts others ☐ Begins to have definite preferences ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ TB skin test (if at risk)

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

18 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed/whole milk ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Uses a cup ☐ Walks ☐ Says 10-20 words ☐ Says "No" ☐ Name one picture/2 colors/ ☐ Follows simple rules/bring me the book ☐ Knows animal sounds ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Discipline/limits ☐ Read to child ☐ Dental caries prevention ☐ Sibling interaction ☐ Nutrition/mealtimes ☐ Defiant behavior/offer child choices ☐ Never leave toddler alone ☐ Growing independence ☐ Encourage expression of wide range of emotions ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Demonstrates increasing independence ☐ Begins to show defiant behavior ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ TB skin test (if at risk) Other ☐

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

24 Months Old **AHCCCS EPSDT Tracking Form**

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Ht:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing (by parent) ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Kicks a ball ☐ stacks 5-6 blocks ☐ 20 word vocabulary ☐ Walks up stairs/runs well ☐ Communicates needs in 2-4 word sentences ☐ Names 6 body parts Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sleep practices ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirection/praise ☐ read to child ☐ Car safety/booster seat/5 pt harness ☐ Learns 5-6 words every week ☐ Provide opportunities for success/choice: 2 items "juice or milk"/"red or blue shirt" ☐ Praise for effort/success ☐ Establish daily routine ☐ Encourage/support wide range of emotions ☐ Trike/bike safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Sense of humor ☐ Demonstrates increasing independence ☐ Plays alongside peers ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Blood Lead test (perform at 24 months) ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

3 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt: %	BMI: %	Ht: %		
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform							
Speech: age appropriate ☐ yes ☐ no		Medications:								

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing (by parent) daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS ☐ Uses imaginary characters ☐ Matches colors and shapes ☐ Counts to 5 ☐ Names self and others ☐ Knows gender ☐ Begins to play: games with simple rules/interactive games ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE:: ☒ INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for: bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ "Monster" fear ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Has words for feelings ☐ Separates easily from parent ☐ Objects to major change in routine ☐ Shows interest in other children ☐ Feels competent ☐ Kind to animals ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Blood Lead Test (perform at 36 – 72 months if not already done) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent Refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐ Yes ☐ No

Revised November 1, 2007

4 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam			Allergies:		Temp:	Pulse:	Resp:	B/P
			OD	OS	OU						
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing (by parent) daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Sings a song ☐ Draws a person with 3 parts ☐ Gives first/last name ☐ Names 6-8 colors/3 shapes ☐ Counts 1-7 objects out loud (not always in order) ☐ Names self and others ☐ Shows interest in other children ☐ Plays interactive with simple rules ☐ Asks/answers who, what, where, why ☐ Follows 2 unrelated directions ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Separates easily from parent ☐ Feels competent ☐ Kind to animals ☐ Objects to major change in routine ☐ Has words for feelings ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ Influenza ☐ PCV ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

5 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN :[X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN:[X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Recognizes most letters/shapes/numbers to 10 ☐ Recognize/identify some letters and phonic sounds ☐ Sorts and counts up to 5 objects ☐ Holds pencil ☐ Cuts with scissors ☐ Cooperates more in group setting ☐ Runs/skips/jumps ☐ Begins to agree with rules ☐ Can button and zip clothing independntly ☐ Goes to bathroom independently ☐ Likes to sing/dance/act ☐ Knows address ☐ Plays board games ☐ Dictates story to adults ☐ Listens to authority figure and follows instructions ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE:[X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Set only 3-5 rules for your child ☐ Car seat <40 lbs/belt positioning booster seat <4'9''/air bags ☐ Other

BEHAVIORAL HEALTH SCREEN:[X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Shows empathy for others ☐ Wants to please & be with friends ☐ Positive about self & abilities ☐ Tells stories of convenience(lying) ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis (to be completed at 5 years) ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test (perform at 36 – 72 months if not already done)

IMMUNIZATIONS: [X] INDICATESORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

6 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam			Allergies:		Temp:	Pulse:	Resp:	B/P
			OD	OS	OU						
Audiometry						Wt:	%	BMI:	%	Ht:	%
☐ WNL	☐ Abnormal		Corrected ☐ yes ☐ no								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS ☐ Language is expressive and understandable ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Provide opportunities for social interaction/invite friends over to play board games/dress up etc. ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Frustration/impulse control ☐ Communication/language ☐ Has friends ☐ Plays well with others/by self ☐ Is liked by other children ☐ Feels capable ☐ Expresses full range of emotions ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐ Yes ☐ No

7 – 8 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam			Allergies:		Temp:	Pulse:	Resp:	B/P
			OD	OS	OU						
Audiometry						Wt:	%	BMI:	%	Ht:	%
☐ WNL	☐ Abnormal		Corrected ☐ yes ☐ no								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL/PATIENT CONCERNS/HISTORY:

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Bullying ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family adjustment/parent responds positively to child ☐ Frustration /impulse control ☐ Communication/language ☐ Comfortable body image ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hep A ☐ MMR ☐ Varicella ☐ Td ☐ Influenza ☐ Hep B ☐ IPV ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Revised November 1, 2007

9 – 12 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses		Allergies:		B/P:	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

PARENTAL/PATIENT CONCERNS:

HEALTH RISK ASSESSMENT: ☐ Early Adolescent GAPS (begin at 10 years) ☐ Other

DENTAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: Early adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STI ☐ Peer refusal skills ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Risks of tattoos/ piercing ☐ After school activities/supervision Bullying ☐ Self control ☐ Other

Behavioral Health Screen: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ Lipid Profile TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred
☐ Tdap **(11 - 12years only)** ☐ Meningococcal **(11 – 12 years only)** ☐ HPV **(11 – 12 years)** ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Td ☐ Influenza ☐ IPV ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

13 – 17 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Parent/Patient Concerns/History:

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: Middle Adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Risk taking (Learning to drive 15 to 17 years) ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Bullying ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Sexual orientation/dating ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ After school activities/supervision ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN & FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ U/A (preferred at 16 yrs) ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

18 – 21 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Patient Concerns/History:

HEALTH RISK ASSESSMENT: ☒ INDICATES ASSESSMENT USED: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: ☒ INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: ☒ INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: ☒ INDICATES ACCOMPLISHMENTS: Late Adolescence: ☐ Abstract thinking ☐ School attendance ☐ Sexuality/orientation ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: ☒ INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Athletic activities ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction/dating ☐ Parenting advice (as appropriate) ☐ Future oriented ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ Job/career planning ☐ Other

BEHAVIORAL HEALTH SCREEN: ☒ INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Philosophical/idealistic ☐ Comfortable body image ☐ Building intimate, complex relationships ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: ☒ INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: ☒ INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: ☒ INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ OB/Gyn ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐Yes ☐No

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

Child's Name:	Male/female
Date of Birth:	

Birth Information:			
Type of Deliver: Vaginal or C-section	Birth Weight:	Birth Length:	
Where was your child born?			
Where there any concerns with mom or baby during the pregnancy or delivery?			
Was your baby born earlier or later than expected?			
Was there use of drugs/alcohol/tobacco/caffeine during the pregnancy?			

Developmental History

Most of the time	Some-times	Rarely	Never	
				Does your child arch/stiffen when picked up?
				Does your child make eye contact when being fed/held?
				Do you have concerns about your child's sleep pattern?
				Does your child look at objects and follow them with her/his eyes?
				Does your child make sounds or babble?
				Does your child respond to your voice by looking at you?
				Does your child have different cries when he/she is upset, uncomfortable or happy?
				Does your baby hold her/his head steady when being held?
				Do you have any concerns about your child's development?

Does your child sleep on his/her (Please circle: stomach back side)?

How do you put your child to sleep?

Medication* **May require Medication Administration forms to be completed.**

Yes	No	
		Does your child take medication on a regular basis? If yes, what:
		Will your child need this medication while at Early Head Start?*
		Does your child have medication for emergency use?* If yes, what?

Dental

Yes	No	
		Does your child have any teeth yet?
		Do you clean your child's teeth/gums?
		Do you have any concerns about your child's teeth?
		Does your child take a fluoride supplement? (6 months and older)

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

Child Health Information: * May indicate need for health care plan.			
Yes	*No*	*Condition*	*If yes, please describe:*
		Allergy other than food*	
		Asthma/breathing concern*	
		Cerebral Palsy*	
		Colic	
		Constipation	
		Diabetes*	
		Diarrhea	
		Frequent earaches/infections	
		Eczema	
		Lead exposure	
		Tuberculosis exposure	
		Fetal alcohol	
		Heart Condition*	
		Low Birth Weight	
		Seizures*	
		Sickle cell	
		Yellow Jaundice	
		Other	
		Surgery	

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

Feeding/Nutrition * May require a health care plan.		
Yes	No	
		Does your child have any **known food allergies?*** If yes, to what food? What happens when child had that food?
		Do you breast feed your baby? How often? How many times in 24 hours?
		Does your child drink from a bottle? How often? How many times in 24 hours? What kind of bottle/nipple do you use?
		Do you feed your child formula? If yes, what brand?
		Has your child been diagnosed with reflux* Did she/he receive treatment? How is the baby doing now?
		Does your child take a vitamin supplement, iron supplement? Please list what kind and for how long:
		Does your baby drink a bottle in bed?
		Has your child been diagnosed with anemia?
		Do you give your child milk? If yes, what kind?
		Do you have any questions or concerns about what/how your baby eats or his/her growth? If yes, what:
		Is your child on WIC? If yes, where:
Which of these food do you offer your child: (Please circle) Eggs Poultry Vegetables Bread Fruit Meat Cereal Rice Juice Please specify which vegetables, fruits, cereal you have offered your child:		

Enrollment Signatures	
Parent:	Date:
Staff:	Date:
Second Year Signatures: Second year, please review information and record any changes with date and initials.	
Parent:	*Date:*
Staff:	*Date:*

Navajo Head Start/Early Head Start
Health/Nutrition History

(Birth to One Year)

INSTRUCTIONS

WHO

1. **The form is for children ages BIRTH to 1 year of age ONLY.**
2. This is to be completed for new enrollees and concludes with a signature on page 3.
3. For second year children, have parents review and record any changes with date, and initials and have them sign on page 3
4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

1. Personal/Birth Information: The first portion will consist of name, birth, and labor.
2. Child Health Information: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child may need health plan completed.
3. Behavioral Information: If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
4. Nutrition Information: If there are any concerns please include in this section and child may need health plan for any known allergies.
5. Allergies/Medications: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
6. Ensure that all signatures and date are completed.

Navajo Head Start/Early Head Start
Health/Nutrition History
(Ages 1 Year-5 Years)

Child's Name: Date of Birth: Male/female	
Birth Information:	
Birth Weight:	Birth Length:
Was your baby born early or late? How early?	
Were there complications during pregnancy or birth? If yes, please describe:	

Does your child have any of the following:			
Yes	No	Health Concern	If yes, please describe:
		Anemia	
		Asthma/breathing problems*	
		Bowel/bladder problems	
		Diabetes*	
		Frequent ear ache/ infections/hearing concerns?	
		Heart condition*	
		Frequent nose bleeds	
		Seizures*	
		Skin Condition	
		Tuberculosis exposure	
		Walking/climbing difficulties	
		Vision concerns/wears glasses	Date of last exam if done:
		Tested for lead?	Date & results:
		Any other concerns? Or any concerns about your child's teeth?	
		Has your child had a serious illness, injury, hospitalization or is being seen by a specialist?	

**Indicates child should have health care plan completed.*

Behavioral Information
Do you have concerns about your child's development or behavior? If yes*, please describe below:

**A referral to mental health services may be required.*

Navajo Head Start/Early Head Start
Health/Nutrition History

Nutrition Information		
Yes	No	Please answer the following:
		Is your child on WIC?
		Do you have any questions about feeding your child? If yes, please explain:
		Are you satisfied with what your child eats? How many meals _____ and snacks_____ are offered? If no, please explain:
		Do you share meals together as a family?
		Does your child drink from a cup?
		Is your child currently breast feeding?
		Do you have any concerns about your child's height or weight or growth?
		Does your child take a vitamin? With fluoride? Does your child take a supplement with iron? Why and how often?
		Does your child currently use any nutritional supplements (pediasure, ensure, herbs, etc)? If yes, how often and for what reason?
		Does your child eat non-food items? Please list:

Medications		
Yes	No	
		Does your child take any medication? Please list, including vitamins:
		*Will your child need to take any medication during preschool hours?
		*If medication is required during school hours, please review Medication Policy with parent and assist to completed necessary paperwork.

Navajo Head Start/Early Head Start

Health/Nutrition History

Allergies
Does your child have any allergies or severe reactions to any of the following? Please circle all that apply, if *other please explain.* **Insect bites/bee stings** **Animals** **Pollens/hay fever** **Medications** **Food** **Other**
Please describe your child's reaction?
How do you treat your child's allergy?
Has the allergy been diagnosed by a doctor?
Does your child have an Epi-pen prescribed?
If your child has a food or milk allergy, we will ask you for documentation from your medical provider that includes a list of foods that can be substituted. *If your child's allergy is severe and an Epi-pen or other medicine is prescribed we will ask you to obtain Medication Administration paperwork and other care plan information from your medical provider.*

Enrollment Signatures	
Parent:	Date:
Staff:	Date:

Second Year Signatures: Second year, please review information and record any changes with date and initials.	
Parent:	Date:
Staff:	Date:

Navajo Head Start/Early Head Start
Health/Nutrition History

INSTRUCTIONS

WHO

1. The form is for children ages 1 year to 5 years of age ONLY.
2. This is to be completed for new enrollees and concludes with a signature on page 3.
3. For second year children, have parents review and record any changes with date, and initials and have them sign on page 3
4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

1. Personal Information: The first portion will consist of name, birth, and labor.
2. Health History: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child should have health plan completed.
3. Behavioral Information: If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
4. Nutrition Information: If there are any concerns please include in this section.
5. Allergies/Medications: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
6. Ensure that all signatures and date are completed.

NAVAJO HEAD START
VISION, HEARING, DENTAL SCREENING

Language Used:
Navajo/English/Other: _____

Center/Homebase: _____

Child's Name: _____ DOB: _____ Age: _____ Gender: _____

VISION SCREENING

	Visual Acuity					
	Right	Left	Pass	Fail	Date	Screener
1st Screening						
Rescreen						

NOTE: If not completed on PE (includes-EPSDT) a screening will be conducted by Head Start staff.

	Stereopsis			
	Pass	Fail	Date	Screener
1st Screening				
Rescreen				

Referred to: _____ Date: _____

HEARING SCREENING:

Date: _____ Screener: _____ Date of Rescreen: _____ Screener: _____

	500 Hz @ 25 db	1000 Hz @ 20 db	2000 Hz @ 20 db	4000 Hz @ 20 db
Right				
Left				

Results: Pass: _____ Fail: _____

	500 Hz @ 25 db	1000 Hz @ 20 db	2000 Hz @ 20 db	4000 Hz @ 20 db
Right				
Left				

Results: Pass: _____ Fail: _____

NOTE: If not completed on PE (includes -EPSDT) a screening will be conducted by Head Start staff.

Visual Observation: _____

Referred to: _____ Date: _____

DENTAL SCREENING: A screening is not the same as a dental exam. In a screening you are only prioritizing the need for the child to see a dentist. The dentist is the person who initiates the dental examination and treatment.

BBTD: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Referred to: _____ Referred by: _____ Date: _____

Priority 1 **EMERGENCY CARE:** Children with dental problems needing immediate care because of pain or conditions that may or soon or is already effecting the child's general health. (Trauma, Pain, Swelling - face/mouth, Abscesses, Infections)

These children should be referred for dental services immediately.

Priority 2 **ROUTINE CARE:** Children with dental problems that need treatment but which do not at the time of the screening, pose a serious general health problem. (obvious cavities, no pain, no swelling or no abscesses).

These children should be referred to dental clinic for routine examination.

Priority 3 **EXAMINATION:** Children with no obvious dental problems that will effect general health. These children will still need to have a dental examination done by a dentist. (No obvious cavities, no pain, no swelling or no abscesses).

These children should be seen by a dentist for an examination.

Applied Fluoride Varnish

Date: _____ Date: _____ Date: _____

By: _____ By: _____ By: _____

Height & Weight (EHS Four Times & HS Two Times)

EHS: Ht:____ Wt:____ Head Circum:____ Date:_____

Ht:____ Wt:____ Head Circum:____ Date:_____

Ht:____ Wt:____ Head Circum:____ Date:_____

Ht:____ Wt:____ Head Circum:____ Date:_____

HS: Ht:____ Wt:____ BMI:____ Date:_____

Ht: ____Wt:____ BMI:____ Date:_____

Revised: 7/31/2012

NAVAJO HEAD START PHYSICAL FORM

Name:	DOB:	Date of Visit:
Chart#:	Parents Name:	

Ht: _____ Wt: _____ BMI: _____ BP: _____ Hemo./Hct: _____

Head Circumference (up to 24 months)_____

Vision: R _____ L _____

Allergies (Food and Medicine):

Medications:

Significant Past Medical History:

Hearing Normal: Yes _____ No _____

Physical Exam	Normal	Abnormal
Skin		
Head/Fontanel		
Speech		
Eyes		
Ears		
Mouth		
Neck		
Chest		
Heart		
Abdomen		
Back		
Genitals		
Extremities		
Neuro		
Fine Motor		
Gross Motor		
Other		

Facility Name: _____

Fluoride Varnish Applied: Yes or No

Wearing Glasses: Yes or No

Previous Referrals:

New Referrals Made:

Blood Lead Testing completed: Yes or No
Note: Results need to be provided.

Explain any abnormal findings on
(speech, development, mental health)

Was the anticipatory guidance completed for
Child: Yes or No

Head Start Follow-up Needed:

_____

Medical Follow-up Needed:

_____

Dental Follow-up Needed:

_____

Medical Care Provider:_____

Signature:_____ Date:_____

Phone#:_____

Notes: if any medication is to be administered during classroom hours please attach a treatment or action plan. Attach a copy of his/her updated immunizations.

Revised: 2/19/2013

NAVAJO HEAD START
DENTAL EXAMINATION & TREATMENT

Child's Name: _____ **Sex:** M☐ F☐ **Date of Birth:** _____

Parents(s) / Guardian: _____ **Chart #:** _____

Center / Home Base: _____ **Teacher / Home Visitor:** _____

I. MEDICAL HEALTH HISTORY: To be completed at interview with parent / guardian

1. Child is reported to have: (√) all that applies

☐	Allergies	☐	Liver Disorder
☐	Asthma	☐	Rheumatic Fever
☐	Bleeding	☐	Sickle Cell Disease
☐	Diabetes	☐	Heart Murmur
☐	Epilepsy	☐	Other

2. If child under a physician's care? ☐Yes ☐No
   Physician's Name: _____
3. Is child now receiving medication? ☐ Yes ☐No
   Type of allergies: _____
4. Is child now receiving:
   Tropical Fluoride Application? ☐ Yes ☐No
   Fluoridated Water? ☐ Yes ☐No ☐ Unknown
   ☐ NTUA ☐ Private Well ☐City
5. Does child need further treatment? ☐Yes ☐No

5. Has child previously seen a dentist? ☐ Yes ☐ No
   Dentist's name: _____
   Date of last visit: _____

II. EXAMINATION / TREATMENT: To be completed by Dentist

A.

Date	Dental Hygiene	ECC			# Filling	# Extraction(s)	Pulp Therapy
		None	Mild	Severe			

Remarks: _____

Signature of Examiner / Date: _____

B.

Date	# Filling	Extractions	Pulp Therapy	Sealents	SSC

III. Is Child Planned Treatment Completed? ☐ Yes ☐No

If not, explain: _____

IV. Recommendation for On-going Dental Care: _____

Referral to Specialist: _____

V. I certify that I have completed the above service(s).

Dentist Signature: _____ **Date:** _____

Revised: 2/19/2013

ON SITE DENTAL

P.O. Box 767
Camp Verde, AZ 86322
(928) 567-1832 Phone
(928) 567-6500 Fax
onsitedentalaz@gmail.com

Please return this form to the school!

DEAR CONCERNED PARENT:

Your child may be eligible to receive routine dental care at no charge! The Indian Health Service has contracted with OnSite Dental to provide care for most Headstart children in your area. OnSite Dental has expanded that program to include your child's school. This care is conveniently provided at the school. OnSite Dental is well known throughout the Native American communities, having provided excellent dental care for over 20 years at numerous locations in Arizona and New Mexico.

To participate in this valuable service, your child must be enrolled in an appropriate New Mexico Medicaid or Arizona AHCCCS program.

Please complete the following information

Child's Name_____ Male____ Female____

Child's Social Security Number_____ Date of Birth____/____/____

Emergency Contact_____ Phone #_____

School Name_____ Teacher's Name_____ Grade____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOUR CHILD:

Has your child had?	NO	YES
Allergy to medication	____	____
Rheumatic Fever	____	____
Psychiatric Treatment	____	____
Seizure Disorder	____	____
Diabetes	____	____
AIDS/HIV Positive	____	____
Hospitalizations	____	____

	NO	YES
Heart Murmur	____	____
Bleeding Disorders	____	____
High Blood Pressure	____	____
Asthma	____	____
Hepatitis/Jaundice	____	____
Anemia	____	____
Latex Allergy	____	____
Other Serious Illness	____	____

Is your child under a Physician's care? NO____ YES____
Is your child taking any medication? ____ ____

PLEASE EXPLAIN ANY "YES" ANSWERS:_____

PLEASE TURN OVER. OTHER SIDE MUST BE COMPLETED AND SIGNED

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination and cleaning, they may require additional dental treatment, including silver fillings, stainless steel crowns, and pulp treatments. In the event no other treatment is practical, removal of the tooth may be necessary.

OnSite dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. Our dentists make the decision to refer very carefully and take all factors into consideration, including the very limited number of general anesthesia appointments available at IHS.

We have had a great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program may affect future benefits your child may receive under private insurance or from another private dentist.

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1. _____ **YES. I give permission for my child to receive treatment!**
2. _____ **No. I do not want my child to receive necessary treatment.**
3. **I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.**

I understand that I may refuse to sign this Consent and Acknowledgement.

X _____ **Date** _____

Parent or Guardian

Please print your name _____

PLEASE TURN OVER AND COMPLETE

Topical Fluoride Permission Form

Dear Parent or Guardian,

Over 80% of American Indian and Alaska Native Head Start children have dental cavities. However, cavities can be prevented through the use of fluoride, dental sealants, and xylitol.

We will provide a fluoride varnish program for Head Start children this year. Because your child is a minor, you consent is needed to allow your child to receive this preventive service.

Fluoride Varnish
Procedure: A high concentration fluoride varnish is painted directly onto the teeth.
Benefits: Fluoride Varnish coats the outside of the tooth and can provide some cavity-fighting power for up to 3 months.

Parental Permission
I give my son or daughter, _____, permission to have fluoride varnish placed on his or her teeth multiple times in a year by a trained staff or provider with prescription or standing orders. I understand the Fluoride Varnish program is a preventive program and the product is safe and effective.

Please list any physical conditions that the school should be aware of (asthma, allergies, recurring illnesses, disabilities, chronic illnesses, etc.):

_____

Fluoride Varnish:

___ I do **NOT** want my child to have fluoride varnish applied.

___ I **DO** want my child to have fluoride varnish applied.

Parent or Guardian Name (print) _____

Signature _____ Date _____

Telephone Number _____

You can prevent cavities at home.
Brush daily with a fluoride toothpaste.

MEDICAL/DENTAL/HOME INSURANCE

*Primary Health Coverage:	At Enrollment		End of Enrollment	
	Yes	No	Yes	No
CHIP				
Combined Medicaid/CHIP				
No Insurance				
Medicaid				
Other:				
Private				
State Funded				

Other Health Coverage	Insurance No.	Medicaid Status	Medical No.

Other Coverage Notes:

, the child:	At Enrollment		End of Enrollment	
	Yes	No	Yes	No
Have an on-going source of continuous accessible medical care.				
Receive services through IHS.				
Receive services migrant.				
Have an on-going source of accessible dental care.				

All info can be found on Enrollment application 1st page

*Did the child receive preventive

*Medical treatment for condition:

Anemia ☐ Hearing ☐ ☐ Lead ☐

Doctor's Name: _____

Address: _____

Telephone Number: _____

Dentist's Name: _____

Address: _____

Telephone Number: _____

Child Name: _____ Date of Birth: _____

: *PIR Question

Revised: 7/31/2012

PATIENT REFERRAL NOTICE

INSTRUCTIONS *(This form may be used by Medical, Dental, and Paramedical personnel to refer DIH Beneficiaries for medical, dental or related services).*

1. TO (Name, title, and address of person or organization or institution to whom referral is made).

2. NAME OF PATIENT (Last Name, First Name, Middle Name)	3. SEX	4. BIRTH DATE	5. REGISTRATION NO.
6. ADDRESS	7. TRIBE		8. RESERVATION

9. ADDITIONAL IDENTIFICATION

10. REASON FOR REFERRAL *(Type of service requested)*

11. SIGNIFICANT MEDICAL OR DENTAL FACTORS *(including diagnosis, prognosis, treatment, etc.)*

12. REPORT BY PARAMEDICAL PERSONNEL

FROM *(Name, title, and address of person making referral)*	14. DATE

Navajo Nation Head Start/Early Head Start

Individual Health Care Plan

IHCP should be completed for children with identified health concerns that may require emergency treatment or modifications to diet or activity such as asthma, seizures, serious allergies, acute/chronic medical conditions.

Child's Name:	Today's Date:
Birth Date:	
Agency/Classroom:	
Health Condition/Diagnosis	
Medications:	Dose/time:
Allergies:	
Dietary Concerns/restrictions:(Please indicate food substitutions)	
Any other concerns/restrictions on activity:	
Parent Signature:	Date:
Doctor Signature:	Date:
Doctor's Phone Number:	
In the event of an emergency, emergency contacts listed on_____ will be contacted if parent is unavailable.	

Navajo Head Start/Early Head Start
Parent/Guardian Permission for Medication Administration

Dear Parent: In order for your child to receive medication while at Head Start or Early Head Start, the program must have your authorization and have all required paperwork completed. Please take a moment to complete this form. Thank you.

Child's Name:
Date of Birth:
Reason Child is taking Medication:
Prescribing Doctor: Doctor's Phone Number:
Name of Medication:
How often/when should it be given:
What is the dose/how much?
Are there any symptoms we should watch for?
I, _____,(parent/guardian name)give my permission for Head Start or Early Head Start staff to give my child, _____,(child's name) the medication as indicated above. ***Date:*** _____ ***Parent Signature:*** _____ ***Date:*** _____ ***Staff Signature:*** _____

I, _____,(parent/guardian, *healthcare professional-print name/title) have trained the following staff to the use of the above medication, including the equipment necessary to use the medication. ***Date:*** _____ ***Signature:*** _____	
A healthcare professional may be asked to provide training if child has a severe illness, an uncommon medication or complicated treatment plan.	*Staff name:*
Staff name:	*Staff name:*
Staff name:	*Staff name:*

Navajo Head Start Medication Dispense Log

Name: _____

Receipt of Medication

Type Medication: _____

Date	Refrigeration		Start Date	End Date	Expiration Date	Dose	Drug Fact Sheet	Doctor's Order	Parent or Guardian Signature	Staff Initials
	Yes	No								

Dispensation Log

Date	Time	Dose	Method	Refusal	Observation	Discussion with Parents or Comments

Medication Returned to Parents

Parent Signature: _____ Date: _____

Staff Signature: _____ Comments: _____

Revised: 8/16/12

COMPARTMENT 3
NUTRITION
School Year: 2012 - 2013

1	Health and Nutrition History – See Compartment 2
2	Parent Consent (WIC), if applicable
3	Child & Adult Care Food Program Medical Statement (if applicable)
4	Infant Feeding Preference (EHS Only)

THE NAVAJO NATION

Navajo Head Start, P.O. Box 3479 • Window Rock, Arizona 86515
• 928.871.6902, Fax 928.871.7866

BEN SHELLY
President

REX LEE JIM
Vice President

PARENT CONSENT FORM

Note: Women, Infant, Child Program (W.I.C) clients contact the nearest W.I.C. Office and for Non-W.I.C. clients take your child to the nearest Indian Health Service (I.H.S) for the following information requested.

****

Early Head Start Only

I, _____, hereby give my consent for the Women, Infants and Children
Client's Name
Program or Indian Health Services to withdraw/release blood for the Hematocrit Reading to the Navajo Head Start-Early Head Start Pregnant Women Program.

_____ _____
Client's Signature Social Security Number

_____ _____
Date Date of Birth

****

Head Start Only

I, _____, hereby give my consent for the Women, Infants, and Children
Parent's Name
Program or Indian Health Services to withdraw/release blood for the Hematocrit Reading of my child, _____, to the Navajo Head Start.
Child's Name

_____ _____
Parent's Signature Mother's Social Security No.

_____ _____
Date Child's Date of Birth

****

_____ _____
Hematocrit Reading Date Given

_____ _____
Provider's Name and Title Date

Arizona Department of Education
Tom Horne, Superintendent of Public Instruction

CHILD & ADULT CARE FOOD PROGRAM

MEDICAL STATEMENT FOR PARTICIPANTS REQUIRING FOOD SUBSTITUTIONS

Name of Participant:	Date of Birth:
Parent Name:	Parent Telephone Number:
Name of Center:	Telephone Number of Center:

Dear Parent/Guardian:

This day care center participates in the Child and Adult Care Food Program (CACFP) and must serve meals and snacks meeting the CACFP requirements. Food substitutions may be made only when supported by a recognizaed medical authority. A recognized medical authority may include, but is not limited to medical physician, registered nurse, or registered dietitian. The recognized medical authority must specify, in writing, the food to be omitted from the participant's diet and the food or choice of foods that may be substituted. Please ask a medical authority to complete and sign this form. Return the completed form to your center.

List the foods to be omitted from the diet and foods that may be substituted		
Foods to be omitted	Allowed Substitutions	Additional Requirements (i.e. special equipment, texture, thickness, etc.
List any additional instructions or requirements		

I certify that the above participant must be provided a special diet or requires special accommodations as indicated above.	
Printed Name	Title
Signature	Date

CACFP INFANT FEEDING PREFERENCE - CENTERS

N .. of infant _____ Date of Birth _____

_____ will feed your infant breast milk provided by you
(name of provider)

and/or we will provide iron fortified infant formula.

The formula we provide is: _____

This center/home/ministry participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants and children. Participation in this program requires caregivers to follow specific meal patterns according to the age of the child being fed.

Policy requires a center/home/ministry participating in the CACFP to offer formula to infants who are in care during meal service times. Parent/guardians, however, may decline what is offered, and supply the infants formula.

Please mark your preference (chose all that apply)	Today's Date _____ Birth - 3 months	Today's Date _____ 4 - 7 months	Today's Date _____ 8 - 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
bring formula for my infant. Please list kind of formula you will bring: _____			

In order to claim meals for reimbursement, the center must provide infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference	Today's Date _____ 4 - 7 months	Today's Date _____ 8 - 11 months
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.		

Signature of Parent/Guardian _____ Date _____

1. This form must be kept on file for each infant enrolled for child care.
2. As situations change, such as a medical authority changing the infant's formula, a new form should be comleted.
3. This form must be kep current and accurate for each infant enrolled for child care until the infant reaches one year age or is no longer on infant formula.
4. the parent/guardian declines the formula and the provider provides meal and/or snack components, the meal may be claimed for reimbursement.
5. If the parent/guardian declines infant meals/snack, meals and snacks may NOT be claimed for reimbursement.

NAVAJO HEAD START

2013-2014 & 2014-2015 Family Engagement / Partnership Building

FE/PB 01: **Subject: Family Services**

Grantee Program must have a Family Partnership

Scope: *Navajo Head Start* networks with surrounding resources to collaborate services based on Family Partnership Building. Family Partnership Building is developed with parents of enrolled children in Early Head Start / Head Start, to meet their needs/strengths through referral process, goal setting and planning. The program will maintain confidentiality and sensitivity of language, culture, and ethnicity.

Policy:

Family Support: Navajo Head Start will respect Head Start Families Culture, Diversity and Ethnic Back Ground to build family support:

Procedures

a. Trainings
   i. Self Sufficiency
   ii. Family Partnership Categories
b. Parental Involvement: General and Leadership
c. Promoting Family Literacy
d. Parent Education
e. Crisis Support
f. Self Sufficiency
g. Honoring Primary Language

2. Head Start / Early Head Start / Case Management for: Navajo Head Start Referrals (inclusive of Early Head Start)
   i. Health Referrals
   ii. Family Referrals
   iii. Other Referrals (ex. Attendance)
3. Family Partnership Agreement (FPA)
   iv. FPA Agreement Referrals
   v. Provide Orientation on Individualized Family Partnership Agreement during enrollment process.
   vi. Should a family decline FPA the Family Engagement Liaison/ teaching staff will do a follow-up in 30 working days for any changes.
   vii. A copy of the FPA will be forwarded to the ERSEA/Family Engagement Liaisons Specialist (NCR Sets: Original to Child's Folder; FE/ERSEA Spec.; FSL; Parent)
   viii. Teaching staff/Family Engagement Liaison will enter enter information into childplus and file original completed form in child's folder in compartment four.

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NOTE: Should a family prefer to meet with teaching staff during the FPA Process instead of the FSL, the Teacher will follow the policy and procedure with the assistance of the FSL and ERSEA/FE Spec.

Case Management:

1. Navajo Head Start Referrals: FEL will maintain confidential case management documents for enrolled Navajo Head Start Families. Navajo Head Start referrals will be documented on case notes for any follow ups and further assessment. This information will be gathered from the from the ChildPlus Reports.
2. Partnership Building: **COMPILING and Categorizing: Partnership Building (PB) data.**

- COMPILING: Family Engagement Liaisons will enter all Family Partnership Agreement Form in Child Plus for compilation and Prioritizing.

- Categorizing
  a. Using PB Form (categories 1-5) FEL will determine the family strengths, readiness and interest
  b. The FEL will use Child Plus Report 4110 to prioritize needs of each family.
- Prioritizing:
  1. Upon the results of the Prioritizing needs the FEL and Family will begin developing short/long term goals using page 2 of the FPA Form. To avoid duplication of services, FELs and Family will review any pre-existing plans and build upon the pre existing plans in collaboration with the following programs:
     - Early Head Start program
     - Home Base program,
     - Self Reliance Nutrition Assistance Program GENERAL ASSISTANCE
     - Social Service OTHERS

  2. Goal Setting:

- Short Term Goals: including but not limited - Written Materials/Handouts, Referrals, Support letters – (COPY ON FILE and entered into Child Plus).

  a. Family Engagement Liaisons will contact surrounding resources through phone calls, internet, conferences, community gatherings, and written referrals/support letters, based on the family readiness and interests.
  b. Family Engagement Liaisons will follow up, completion/accomplishment of short term goals recording visits on proper documentation. (Parent contact form, FPA page 2, and Child Plus). Family Engagement Liaisons will make follow-up through home visits, phone calls, parent/teacher conferences, and setting up appointments for families.
  c. FEL will copy proper documentation to close short term goals and record in Child Plus.

- Long Term Goals: (Any Pending ongoing, at risk, special and / or sensitive cases that requires the full attention of Family Content Specialists (ERSEA/FESpec, FEL, DIS and MH).

  a. Family Engagement Liaisons will contact surrounding resources through phone calls, internet, conferences, community gatherings, and written referrals/support letters, based on the family readiness and interests.

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b. Family Engagement Liaisons will conduct a follow up, completion/ .nplishment of Long term goals recording visits on proper documentation. (Parent contact form, FPA page 2 and Child Plus).
c. Family Engagement Liaisons will make follow-up through home visits, phone calls, parent/teacher conferences, and setting up appointments for families.
d. Case Management meetings will be held on a monthly basis to update family data, debriefing of case loads to assist with cases for i.e. resources, direction and recommendations.

3 a. Referral Process: Navajo Head Start Referrals and Partnership Building – identified needs will be referred to available resources.

a) A Home visit shall be conducted by the Teaching staff and/or FEL
b) Navajo Head Start Staff (ALL) will Fill out referral forms and write support letters to resources in reference of identified needs of enrolled families and entered into child Plus. Staff may also use the Individual follow up / action step plan form to assist staff in organizing their case plans.
c) Navajo Head Start Staff will contact identified resources utilizing written referrals and/or support letters through:
   - FAX/e-mail
   - Mail
   - Telephone
   - Tesxting
   - In person
d) ERSEA/FE Spec, FEL and/or teaching staff will make a follow-up on all referrals submitted to identified resources to ensure families needs are met and documented on the referral/follow-up log.. FEL will maintain original documents in child's folder and enter into Child Plus.

NOTE: Should an emergency crisis or sensitive case arise: (SCAN, Displacement of Home, Domestic Violence, Death and Natural Disasters).
1. Refer to the Navajo Health Plan Booklet
2. Refer to the NHS Disaster Plan
3. Suspected child abuse and neglect (SCAN) Policy and Procedure
4. Social Services
5. Mental Health Services

3 b. Tracking: Navajo Head Start uses Child Plus to track Partnership Building with Families:

(CHILD PLUS REPORTS:
1.

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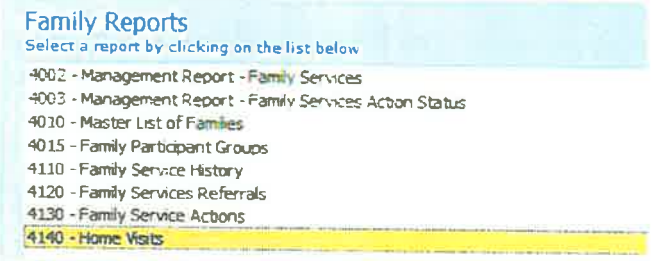

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3 c. Follow Up – All Follow ups are documented on the individual Follow up/Action Step Plan , Parent Contact and entered into Child Plus.

a. Navajo Head Start Referrals
b. Family Partnership Agreement

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Follow Up includes:

1. Transition
2. Parent Trainings, Referrals, and Case Management Meetings

Review and up-date of pre-existing plans Closures: of Family Accomplishments and Reflections are Documented on the FPA page 2 goal setting and recorded in Child Plus.

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3 d. Monthly Case Management Meetings

1. Meetings are designated each month in the school year calendar;

Facilitator: ERSEA/FE Spec.; Participants: FEIs and DIS / Mental Health Coordinators and Mental Health Consultants; but; when a particular case and child is discussed that needs further or additional information the specific Head Start Content Specialist that has a vested duty to assist the child will need to be in attendance for example Information discussed is kept confidential 3 e. Record Keeping:

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1. Child Plus
2. Referrals/Forms
3. Case Notes
4. Case Management Meeting: Case Staff Documentation Form and Case Progress Notes
5. Emergency Crisis Form
6. Onsite Visitation Form
7. Parent Contact Form
8. Partnership Building Form
9. Goal Setting
10. Confidentiality Folder Review Control Sheet

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3 f. Case Management Tool Kit

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1. . cy and Procedure
2. Tracking
3. Guidance
4. Forms
5. Child Plus

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FE/PB 02 **Subject: Accessing Community Services and Resources**

Navajo Head Start works with local resources access their family needs.

Scope:

Navajo Head Start works collaboratively with all participating parents to identify and continually access, either directly or through referrals; services and resources that are responsive to each family's needs, interests and goals.

Policy

Navajo Head Start works with Self Reliance, Local Chapters, American Red Cross, and local Churches/Charities, Navajo Clothing Program and other outside entities to meet family needs

Procedures:

1.

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Deleted: Family Partnership Agreement identifying each family's interest/ goals: FSC.FSL, PIC and teaching staff will work collaboratively with Resources for such cases as:

A1. Families referred to resources for Emergency/crisis assistance using the Emergency Crisis Form and documented information is updated into child plus in the areas of:

- Food
- Housing
- Clothing
- Transportation Financial assistance

NOTE: Emergency Crisis or Sensitive Issues: (Child Sexual Abuse and Neglect, Displacement of Home, Domestic Violence, Death and Natural Disasters).

1. Refer to the Navajo Health Plan Booklet
2. Refer to the NHS Disaster Plan
3. Child Abuse and Neglect Policy and Procedure
4. Social Services
5. Mental Health Services

b) Homeless: Navajo Head Start will **respect Head Start Families Culture, Diversity and Ethnic Back Ground** to build family support. Though homeless is defined as "a lack of permanent housing (not having a fixed, regular, adequate residence) resulting from extreme poverty, or, in the case of unaccompanied youth, the lack of a safe and stable living environment".

i. The term "homeless" is broadly defined by the McKinney-Vento Act's Education for Homeless Children and Youth Program, as quoted (below).The term "unaccompanied youth" includes youth in homeless situations who are not in the physical custody of a parent or guardian.

ii. Preschool children, migrant children, and youth whose parents will not permit them to live at home or who have run away from home (even if their parents are willing to have them return home) are considered homeless if they fit the definition.

c) Education and other appropriate interventions, including opportunities for parents to participate in counseling programs and/or receive information on:

- Mental Health Services.
- Substance Abuse
- Child Abuse and Neglect
- Domestic Violence

d) Opportunities for continuing education and employment training, utilizing surrounding resources within the community.

- GED/High School courses
- College/University courses
- Vocational courses/trainings

e) Additional services and resources including assistance and / or referrals for::

- Self-Employment
- Enhancing Financial Literacy/Budget
- Home-Buyer Assistance
- Medical Assistance (Medicaid/AHCCCS)

f) The Licensed Mental Health Professional must provide services in order of priority listed below, to align with Head Start Performance Standards:

1. Priority 1 – Any and all services directly or indirectly delivered for children.

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Priority 2 – Any and all services directly or indirectly delivered for staff.

3. Priority 3 – Any and all services directly or indirectly delivered for parents/guardians/families of children, and only in cases of emergency situations that directly or indirectly impacts the child. Sessions for parents/guardians/families will not exceed 8 sessions, unless a request is done in writing to exceed 8 sessions. Requests can be done by the client and/or the Licensed Mental Health Professional.

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FE/PB 03 **Subject: Services to Pregnant Woman, infants, and toddlers**

; Navajo Head Start has an Early Head Start Program Services to Pregnant Women, Infants, and Toddlers.

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Scope: *Navajo Head Start* assists pregnant women in receiving comprehensive prenatal and postpartum care through referrals, immediately after enrollment in the Early Head Start program.

Policy

Develop Family Partnership Agreement that outlines and individualizes services for mothers to receive during their prenatal care will include: (EHS staff serves as advocates and Liaison between pregnant women and health care providers)

Procedures:

1. EHS Home Visitor and expected mother will complete the nutrition assessment.
2. Encourage expectant mother to attend all prenatal appoints (Comprehensive Prenatal Health Care):
    a. Health promotion
    b. Medical examinations
    c. Dental examinations

3. Mental Health interventions

A. The Licensed Mental Health Professional must provide services in order of priority listed below, to align with Head Start Performance Standards:

i. Priority 1 – Any and all services directly or indirectly delivered for children.
ii. Priority 2 – Any and all services directly or indirectly delivered for staff.
iii. Priority 3 – Any and all services directly or indirectly delivered for parents/guardians/families of children, and only in cases of emergency situations that directly or indirectly impacts the child. Sessions for parents/guardians/families will not exceed 8 sessions, unless a request is done in writing to exceed 8 sessions. Requests can be done by the client and/or the Licensed Mental Health Professional.

B. Substance abuse prevention and treatment
C. Prenatal health education efforts include information about:

i. Fetal Development, including the risks of smoking and drinking alcohol.
ii. What to expect during labor and delivery.
iii. Nutrition Education
iv. Postpartum Recovery, including maternal depression.

D. Breastfeeding Education:

a. Provide benefits of breastfeeding.
b. Being sensitive to cultural differences.
c. Support mothers who chooses to breastfeed by:
    - Providing a quiet, comfortable, and private, space.
    - Providing mothers necessary fluids or nutritious snacks.

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Exhibit A: Service Area Case Management Tracking Form: FSLs will be doing their own service areas and submitted to Agency

2. Exhibit B: Agency Case Management Tracking Form: FSC will compile Exhibit B in overall and submitted to Central

3. Exhibit C: Navajo Head Start Case Management Tracking Form: Central Office will compile for each Agency

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b. Family Partnership Agreement: Tracking will be report on a quarterly basis (October, January, May)

1. Exhibit D: Center/Home Base Family Partnership Tracking; FSL will compile all information from the Family Partnership Agreement and forward to Agency.

2. Exhibit E: Service Area Family Partnership Tracking; FSC will compile all information from Exhibit D and submitted to Central

3. Exhibit F: Navajo Head Start Family Partnership Tracking; all information for Exhibit E will be compiled on this form and reported.

c. Family Profile Tracking: Tracking will be compiled three times a school year by the FSC (October, January, and May).

1. Exhibit G: Family Profile Tracking

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Related Regulations: 1304.40 a; 1304.40 a 1; 1304.40 a 2; 1304.40 a 3; 1304.40 a 4; 1304.40 a 5; 1306.33 b

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Develop Family Partnership Agreement that outlines and individualizes services for mothers to receive during their prenatal care will include: (EHS staff serves as advocates and Liaison between pregnant women and health care providers)

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Develop Family Partnership Agreement that outlines and individualizes services for mothers to receive during their prenatal care will include: (EHS staff serves as advocates and Liaison between pregnant women and health care providers)

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TABLE OF CONTENTS

NAVAJO HEAD START
EARLY CHILDHOOD MENTAL HEALTH POLICIES AND PROCEDURES

Policy ID: NHS MENTAL HEALTH 01 **Subject: Prevention and Early Intervention**

Performance Objective: Navajo Head Start (NHS) must collaborate with parents and community members to educate them about the importance of early childhood mental health for children, families and staff.

Operational Procedures:

Navajo Head Start must conduct trainings to educate parents/guardians and staff to comprehend the importance of early childhood mental health wellness to support their overall growth and development.

A. The information will assist in addressing early childhood mental health needs:
   1. Education for Staff and Families: Trainings will be provided according to annual educational trainings for staff and parents specific to mental health topics.
   2. Solicitation of parent input: Parent input must be obtained to complete the Social/Emotional checklist.
   3. The Social/Emotional Checklist will be completed ~~if needed~~ and utilized if there is a child behavioral concern in the classroom setting, or if the Brigance results indicates a need for further ~~assessment, observation~~ and follow recommended recommendation thereafter.
   4. Training Topics (include but are not limited to the following):
      a. Attachment: promote a nurturing relationship with primary caregivers.
      b. Separation: encourage primary caregiver's participation to establishing positive separation and reunion practices.
      c. Child Development: information collected by parents/guardians will provide a better understanding of a child's behavior, which will include prenatal health through the current age of the child.
      d. Recognizing and Understanding Behavior: cultural sensitivity will be taken into account for each child's/family when sudden changes in child behavior occurs.
      e. Supporting new parents during pregnancy, during the first few months after birth; and to provide support and assistance in understanding the development of their newborn through childhood, and adolescents.
   5. Encourage the importance of a nurturing, stable and supportive environment at home and in the classroom.
   6. Support parents/guardians/families in their child's behavior intervention process

Related regulations: 1304.24 a; 1304.24 a (1) (i-vi); 1304.40

Policy ID: NHS EARLY CHILDHOOD MENTAL HEALTH 02 Subject: Prevention and Early Intervention

Performance Objective: Navajo Head Start Licensed Mental Health Professionals will provide early childhood mental health services and trainings for children, families, and staff.

Operational Procedures:
Navajo Head Start's License Mental Health Professionals must provide early childhood mental health services on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in a family or staff's concerns about a child's early childhood mental health. Early Childhood Mental Health services may extend into the summer months per budget allocations, client needs and continuity of services

for Navajo Head Start children, families and staff. In cases of emergencies/crisis for individualize services for parents/guardians/families, referrals will be made to locate community resources along with referrals to Navajo Head Start's Licensed Mental Health Professionals.

A. The Licensed Mental Health Professional must:

1. Implement program policies per Navajo Nation Personnel Policies, contractual agreements, job descriptions, and/or scope of work, and Navajo Head Start Policies and Service Delivery Plans.
2. Resources: Utilize community resources to assist children, families, and staff with early childhood mental health services, as needed.
3. Review all children's Social/Emotional Checklist in accordance to the need of a child's behavioral concern, ~~if needed~~.
4. Licensed Mental Health Consultants will provide feedback/summarizes to teachers/center staff/home visitors and the Mental Health Coordinator's.
5. Conduct classroom, home base, and Early Head Start observations two times a year.
6. Provide written on-site observation reports.
7. Provide copies of reports to the classroom and home base programs with feedback and discussion with the staff to assist with their comprehension of observation reports.
8. Provide written documentation that children and their families, and staff are receiving services.
9. Provide early childhood mental health education through individual and group settings for children and their families.
10. Provide early childhood mental health education through individual and group settings for staff to understand and supplement their classroom or home base environments/curriculum.
11. Provide on-site consultation on a regular basis.
12. Provide a supportive contact to each center or home base program at least once a month via phone call, visit or staff/parent meeting.
13. Provide professional early childhood mental health services to Navajo Head Start children, and staff through individual sessions or group sessions based on client needs.
14. Must seek written consent to provide individualized services from parents/guardians when appropriate.

B. The Licensed Mental Health Professional must provide services in order of priority listed below, to align with Head Start Performance Standards;

1. Priority 1 – Any and all services directly or indirectly delivered for children.
2. Priority 2 – Any and all services directly or indirectly delivered for staff pertaining to their work with children. For staff needing services for personal issues, Mental Health Consultants can provide services at staff's written request. Mental Health Consultants will provide assistance to staff with the goal of having staff work effectively and positively with children and their families.
3. Priority 3 – Any and all services directly or indirectly delivered for parents/guardians/families will not exceed 8 sessions, unless a request is done in writing to exceed 8 sessions. Requests can be done by the client and/or the Licensed Mental Health Professional.

C. The Licensed Mental Health Professional must provide early childhood mental health services, ~~and,~~ guidance and support when referring clients as needed for services for the following:

1. Psychiatric Services
2. Psycho Therapy
3. Substance Abuse/Addiction Services
4. Marriage and Family Therapy
5. Professional for Social Work services
6. Counseling Services
7. Traditional Practitioner Services
8. Other Faith Based Counseling Services

9. Crisis Prevention and Intervention Services
10. Implement Best Practices in supporting direst service staff in using Positive Behavior Interventions and Support in working with children.
11. Establish and facilitate family/staff support groups, as needed.

Related Regulations: 1304.24. a (2)

Policy ID: NHS EARLY CHILDHOOD MENTAL HEALTH 03 Subject: Prevention and Early Intervention

Performance Objective: Navajo Early Childhood Head Start Mental Health Coordinators will assist and support the Licensed Mental Health Professional in coordinating and managing the mental health services and education/trainings for children, families, and staff within their respective agencies.

Operational Procedures:
The Mental Health Coordinator and the Licensed Mental Health Professional must provide regularly scheduled early childhood mental health services throughout the school year. Early Childhood Mental Health services may extend into the summer months per client needs and continuity in service delivery for Navajo Head Start children, families and staff.

D. The Mental Health Coordinator must:

1. On-site visitations will be done at least once every two months for all classroom and home base programs.
2. Implement program policies per Navajo Nation Personal Policies, job descriptions, and/or scope of work, and Navajo Head Start Policies and Service Delivery Plans.
3. Resources: Utilize and collaborate with community resources to assist children, families, and staff with early childhood mental health services as needed.
4. Referrals must be completed, submitted, tracked and forwarded to the appropriate service providers.
5. Review, file, track and monitor all Social/Emotional Checklists, Brigance, Devereux Early Childhood Assessment (DECA) or the Devereux Early Childhood Assessment-Infant Toddler (DECA-I/T), in accordance to the needs of child behavioral concerns, and/or Brigance results.
6. Review, file, track and monitor classroom observation reports.
7. Review, file, track and monitor written documentation that supports children and their families are receiving services.
8. Provide early childhood mental health education, when appropriate and with assistance from a Licensed Mental Health Professional, through individual and group settings for children and their families.
9. File all mental health services documentation while maintaining confidentiality. Locked file cabinets must be used to file documents.
10. Research, attend trainings, and assist in coordinating the initial implementation of Positive Behavior Intervention and supports in Navajo Head Start.
11. Initiate introduction of Best Practices in supporting the staff whom provide direct services in using Positive Behavior Interventions and Supports when working with children, where applicable.
12. Mental Health Coordinators will work with Licensed Mental Health Professionals in reporting mental health services and hours of services delivered in monthly reports. For Program information reporting (PIR), mental health service hours will be calculated in increments of quarter hours; ie., 1.00=1 hour, 1.25=1 hour 15 minutes, 1.50 hours=1 hour 30 minutes, and 1.75 hours=1 hour and 45 minutes, etc.
13. Must attend all agency staff meetings, Family Service Liaison meetings, Education Component meetings, to ensure thorough early childhood mental health service delivery for children and families.
14. Will attend all ~~Conscious Discipline~~ best practices meetings with Licensed Mental Health Professionals, Consultants, etc.

Related Regulations: 1304.24 a 3; 1304.24 a 3 i; 1304.24 a 3 ii; 1304.24 a 3 iii; 1304.24 a 3 iv

Mental Health

Standard 1304.24 (a)(1)(i-vi); 1304.40(f)

Purpose: Early Childhood Mental Health: Coordinate with Mental Health Professionals to provide quality, culturally sensitive mental health services for children for families, and staff.

Objective: Scheduling of Services; Established Early Childhood mental health training plans for parents and staff to meet the children needs.

Plan of Action:

1. The Mental Health Professional-shall, on a schedule of sufficient frequency, provide timely and effective identification of and intervention in, family and staff concerns about early childhood mental health. Navajo Head Start' on-site visits will be at the minimum of 2 hours per each head start center, home-based centers and home-based centers, consultations, observations or follow-ups for children/families/staff. Monthly schedules will be provided before the 1st of every month to each center, home base program, and Mental Health/Disability Coordinator for respective agencies.

2. The Mental Health Professional must collaborate with program staff, and parents to create and provide a schedule of regular on-site early childhood mental health consultations, sessions, observations, and follow-up visits.

3. The mental health professional shall provide a schedule of on-site trainings and support groups for parents and staff. Such schedules shall be provided to the Mental Health/Disability Coordinators (Region and Central), Administrative Staff member at regional offices, classrooms and home base programs.

4. Service Delivery Time Frame: Early Childhood Mental Health services will be provided during the school year and exceptions may be granted to provide services through the summer based on client needs, case loads and best practices with continuity of services.

Responsible: Mental Health Professional, Mental Health/Disability Specialist, Mental Health/Disability Coordinators, Sr. Education Specialist, Parent Involvement Coordinator, Administrative Assistant, and other key staff as needed.

Reference: Family Partnership Agreement, Mental Health Parent and Staff training Plan relating to Early Childhood Mental Health topics, and Navajo Head Start Policies and Procedures.

Standards: 1304.24 (a)(1)(i-vi); 1304.40 (f)

Purpose: Services for Children (Birth to 5 Years of age/Pregnant Women Program):

Plan of action:

1. For children identified as needing assistance per referrals from the social-emotional checklist data, mental health professional, parents, or staff, periodic conferences will be held formally or informally with parents and/or staff. Conferences will take place to collaborate and provide support for developmentally appropriate practices in the home and in the classroom to assist the identified child/children.

2. The mental health professional will collaborate with local community programs and resources to assist the identified behavioral and early childhood mental health concerns of an individual child or group of children.

3. The mental health professional will provide individual counseling sessions to children who are identified as needing assistance.

4. Review of Behavioral Support Plan will be implemented as needed for children. Review of Behavioral Support Plan will be based on a decision from the review of Behavioral Support Plan that will consist of at least the following members:

   a. Parent/Guardian
   b. Teacher
   c. Mental Health Coordinator
   d. Licensed Mental Health Professional (as needed)

5. Crisis Prevention and Intervention Services

Responsibility-Mental Health/Disability Specialist, Mental Health/Disability Coordinators, Mental Health Professional, Sr. Education Specialist, Mental Health Professional,

Reference: Navajo Head Start Mental Health Contracts, Community Resources, Navajo Head Start Policies and Procedures.

Standards 1304.24 (a)(3)(i-iv); 1304.24 (a)(3)(i-iv)-

Purpose: Early Head Start Services

Plan of Action:

1. The mental health professional will provide early childhood mental health services to infants, toddlers, and pregnant women participating in the Early Head Start program through individual sessions or group socialization activities to foster and strengthen healthy, positive parent-child relationships.

2. The mental health professional will provide early childhood mental health services and education for staff to assist them with providing quality services and to implement practices that are responsive to infants, toddlers, and pregnant women and their rapidly changing needs.

Responsible:

Mental Health Professional (s), Mental Health/Disability Specialist, Mental Health/Disability Coordinators, Disabilities, Mental Health Professionals, Sr. Education Specialist, etc.

Reference:
Navajo Head Start Mental Health Contracts, Community Resources, Navajo Head Start Policies and Procedures.

Standards: 1304.24(a)(2)

Purpose: Education and Support Groups

Plan of Action:

1. The mental health professional must promote early childhood mental wellness by providing individual and group education for staff and parents regarding mental health topics/issues, providing positive environments at home and in the classroom, and on building nurturing parent-child relationships.
2. The mental health professional must promote early childhood mental wellness by providing support groups for staff regarding their early childhood mental health issues.
3. The mental health professional must promote early childhood mental wellness by providing support groups for parents regarding their early childhood mental health issues.
4. Positive Behavior Interventions and Supports will begin to be implemented and taught Navajo Head Start parents, and Navajo Head Start staff to support and provide quality service delivery for children.
5. Training and technical assistance to parents and staff.

Training Topics to include, but not be limited to, the following:

- Domestic Violence
- Stress Management
- Anger Management
- Early Childhood Development
- Conflict Resolution, etc.
- Impact of Trauma on Children/Families
- Early Brain Development
- Developing Positive Self-Esteem in Children
- FAS Prevention / Education
- Positive Behavior Interventions and Supports
- Suspected Child Abuse and Neglect Training (SCAN),
- Implementing and Incorporating: Conscious Discipline (Hand On),
- Conscious Discipline Management,
- Classroom Management,
- Improving Relationships between staff and children
- Promoting Alternative Thinking Strategies

Responsible:
Mental Health Professional(s), Sr. Education Specialist, Parent Involvement Coordinator, Mental Health/Disabilities Specialist, Education Specialists, Family Service Liaisons, Home Visitors and other pertinent staff as needed.

Reference:
Navajo Head Start Mental Health Contracts, Community Resources, Navajo Head Start Policies and Procedures

Referrals for children, families and staff

Purpose: To provide Early Childhood Mental Health services for children and their families; and to provide quality early childhood mental health services to staff in order to support their personal, emotional professional development to enhance service delivery for Navajo Head Start children and parent/families.

Plan of actions:

Referrals will be acted upon in a timely manner, and service delivery will be provided, in order of importance, for:

1. Children
2. Parents/Families
3. Staff

Services for staff will be provided to support the personal, emotional professional development to ensure quality service delivery for children and their parents/families.
Crisis situations will also take precedence when addressing referrals.

Responsible:
Mental Health Professional, Mental Health/Disabilities Specialist, Mental Health/ Disability Coordinator, Education Specialists, Family Service Liaisons, Home Visitors and other pertinent staff as needed.Navajo Head Start Policies and Procedures,

Reference:
Navajo Head Start policies and Procedures, Classroom Observation, Staff, Parents.