Common Findings Health

Record Review
2016-2017

Any concerns about your child's behavior?

Child is evaluated or has received a behavioral health diagnosis?

Would you like to be contacted by a Behavior Health Specialist?

Explain/Comments

V. Immunization History

*Is child up-to-date on all immunizations appropriate for his/her age ? Yes

*Has child received all immunizations possible at this time but has not receive all immunizations appropriate for his/her age ?

*Child Met State's guidelines for an exemption from immunizations.

*Has received no immunizations.

None of the above

Explain/Comments

VI. Dental Information

Do you have dental insurance? If yes, specify dental plan Yes

Medicaid

Does the child have an Ongoing Source of Continuous and Accessible Dental Care? (Dental Home)

Dentist Name / Date of last visit

Were there any problems for the child/Comments No

VII. Nutrition Assessment

1.	Does your child's weight appear normal?	Yes
2.	Does your child eat fruits and vegetables?	No
3.	Is your child a picky eater now?	Yes
4.	In the past six months, was your child found to be anemic (low blood iron)?	No
5.	Is your child involved in active play daily?	Yes
6.	Does your child have diarrhea frequently?	No
7.	Does your child have constipation frequently?	No
8.	Does your child vomit frequently?	No
9.	Does your child drink from a baby bottle now?	No
10.	Does your child have difficulty chewing or swallowing now?	No
11.	Do you have any concerns about you child's growth nutrition, or eating?	
12.	Does your family currently recieve services under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)?	
13.	Does your child drink city water?	
14.	Does your child drink well water?	
15.	Does your child drink bottled water?	

	Primary Insurance	Anthem blue cross / blue shield
	Medical Home Intervention	
2.	Do you use the DO NOT MARK THIS QUESTION?	
	If yes, what city?	
	Date of last physical?	
3.	Do you have "regular" Medicaid?	yes
4.	Do you have "emergency only" or KCHIP?	no
5.	Do you have Healthy Families DO NOT MARK THIS QUESTION?	
6.	Do you have private / other health insurance?	Yes Anthem blue cross / blue shield
	Comments:	Conventry Medicaid

XI. Health History Consents Section

1.	Dental screening/exam and treatments (to detect problems with teeth and gums)	Yes
2.	Vision screening/exam (to detect problems with vision).	Yes
3.	Auditory/Hearing screening (to detect problems with the ears)	Yes
4.	Blood pressure screenings (if not noted on the physical exam).	Yes
5.	Nutritional/growth screening and referral (to detect problems with delayed growth/overweight/underweight children)	Yes
6.	Speech and language screenings (to detect problems with speaking and understanding).	Yes
7.	Developmental screening (to assess levels in language, cognition, visual, small motor, gross motor, social, and emotional aspects).	Yes
8.	Behavioral observations (to further assess social and emotional development)	Yes
9.	In cases of emergency medical/dental care, I give my permission to Head Start staff to secure needed emergency medical care if parents/guardian cannot be immediately contacted.	Yes
10.	That necessary health information concerning my child may be released to the appropriate agencies assisting in the care of my child and the school my child will be attending after Head Start.	Yes
11.	Blood test to check lead levels and/or anemia, if no results are available.	Yes
12.	To transport children by Head Start staff to medical /dental appointments as needed.	Yes
13.	To allow agency staff to make home visits during the school year at my convenience.	Yes
14.	That my child will be in attendance in the program every day that he/she is able.	Yes
15.	That any picture taken of my child may be used in newspapers, displays, bulletin boards or other types of educational publications.	Yes
16.	That my child may accompany his/her class on all scheduled field trips that I have received all specific information prior to each trip. I understand that children will be accompanied by teaching staff and volunteers and that I may choose to attend also.	Yes
17.	To provide the required proof of birth and immunization records on my child.	Yes
	Comments:	

Allergy Questionnaire

Child' Name: [redacted] Birthdate: [redacted]

Has your child been diagnosed as having allergies by a medical professional?
Yes/NO If so, who is the Doctor? Hama Phone # 586-1173

When was child diagnosed as having allergy/allergies? @ 1 1/2 yr old

Has your child been in the Emergency room for this? Yes / NO When: ____

Has child been hospitalized for serve allergy / allergies? Yes / NO When: ____

Does your child take currently prescribed medication for allergy/allergies? Yes / NO If so, list medication and when given: ____

What does your child have allergy/ allergies to? Please list: cow milk or ice cream

Can you identify any triggers that cause an allergy attack: example: insects, pollen, seasonal changes, etc. drinking cow milk.

What are some Signs & Symptoms your child may exhibit if having an allergy problem? Please explain: extreme severe diarrhea

Will child need an Epi Pen or Benadryl or any medication keep at school? Yes /NO
*(If yes, have doctor complete permission form for Prescribed or Over-the-Counter Medications) and do health care plan

Parent / Guardian Signature [redacted] Date: 8-4-16

Preventive Health Questionnaire

Child's Tuberculosis Risk Assessment

Child's Name: [redacted] Birthday: [redacted]

Please circle the Yes or the box after each question

	Yes	No
1. Has child ever had a *positive* TB skin test or chest x-ray? When? _____	☐	☒
2. Had contact with person with confirmed or suspected infectious tuberculosis (Family member or friend)	☐	☒
3. Has child emigrated from a foreign country where there is a history of Tuberculosis? (Asia, Middle East, Africa, Latin America)	☐	☒
4. Has child traveled to a foreign county or had contact with a native person from such a country where there is a history of tuberculosis? (Countries other than United States, Canada, New Zealand, Western Countries)	☐	☒

Child's Written Lead Risk Assessment

1. Does child live in or visit a house with peeling or chipping paint built before 1950?	☐	☒
2. Does child live or visit a house built before 1978 with remodeling or renovations taking place? (Remodeling meaning other than painting, carpet or wall paper removal)	☐	☒
3. Does child have a family member or playmate being treated for abnormal blood lead level?	☐	☒
4. Does child live with an adult whose job or hobby involves exposure to lead? (Working on a farm, bridge, tunnel, or highway construction areas, or with batteries, ammunition, or on firing range.)	☐	☒
5. Does child eat non- food items that may contain lead such as paint chips, dirt, and crayons, etc?	☐	☒
6. Does child receive home or folk remedies that may contain lead or use pottery or ceramics dishware bought outside the USA for drinking and cooking? (Dishware *not bought* in the United States)	☐	☒
7. Has child had a change in residency or custody since last blood lead Screening?	☐	☒

Completed By: [redacted] Date: 6-23-16

Parent/guardian signature

Note: If any questions are answered yes, follow-up must be obtained and documented below.

Date: _____ Person making contact: _____

Person contacted (Name, Title & Organization) _____

_____

Plan of action if any: _____

_____

Treatment Status	No Problem Suspected
Referred To	Comments
Previous Results	07-22-2015 (Age At Exam) 3y / 2m / 14d Performed By Physician Blood Pressure Normal Blood Result /85/56 (TS) No Problem Suspected Next Due 07-22-2016

Lead Screening (Next Due: 08-16-2017)

Performed By	Staff	Result	Exam Date	Treatment
Lead Screen	12mo Normal	Passed Assessment (Assessment)	08-16-2016 4y / 3m / 8d	

Treatment Status	No Problem Suspected
Referred To	Comments: Passed Assessment
Previous Results	08-07-2015 (Age At Exam) 3y / 2m / 29d Performed By Staff (R) 6mo Normal passed (Assessment) Next Due 08-07-2016 (TS) No Problem Suspected (C) passed assessment 05-14-2013 (Age At Exam) 1y / 0m / 6d Performed By Physician (R) 18mo Normal Low (Screening) Next Due: 05-14-2017 (TS) No Problem Suspected

Physical (Next Due: 08-08-2017)

Performed By	Physician				Exam Date	08-08-2016 4y / 0m / 7d
Posture/Gait	Normal	General Appearance	Normal	Speech	Normal	
Head	Normal	Neck	Normal	Teeth	Normal	
Glands	Normal	Heart	Normal	Lungs	Normal	
Bones/Joints/Muscle	Normal	Abdomen	Normal	Genitalia	Normal	
Skin	Normal	Back	Normal	Other	Normal	
Treatment Status	No Problem Suspected			Specify		
Referred To		Treatment				
Well-Baby Check?	No	Intervals				

Cholesterol			y / m / d
Treatment Status	No Problem Suspected		
Referred To	Comments		
Previous Results			

Lead Screening (Next Due: 11-07-2017)

Performed By	Staff	Result	Exam Date	Treatment
Lead Screen	(Screening)		11-07-2016 3y / 6m / 4d	

Treatment Status	Refused/Not Needed
Referred To	Comments
Previous Results	07-21-2016 (Age At Exam) 3y / 2m / 18d Performed By Staff (R) 12mo Normal PASS (Screening) Next Due 07-21-2017 (TS) No Problem Suspected

Assessment

Physical (Next Due: 04-29-2017)

Performed By	Collaborative Agency			Exam Date	04-29-2016 2y / 11m / 26d
Posture/Gait	Normal	General Appearance	Normal	Speech	Normal
Head	Normal	Nose	Normal	Teeth	Normal
Glands	Normal	Heart	Normal	Lungs	Normal
Bones/Joints/Muscle	Normal	Abdomen	Normal	Genitalia	Normal
Skin	Normal	Back	Normal	Other	Normal
Treatment Status	No Problem Suspected			Specify	
Referred To		Treatment			
Well-Baby Check?	No	Intervals			
Comments					
Previous Results					

Dental (Next Due: 03-02-2017) Dental Chart

Performed By	Dentist	Exam Date (Age at Exam)	03-02-2016 2y / 9m / 26d

COMMONWEALTH OF KENTUCKY

IMMUNIZATION CERTIFICATE

(Required for each child enrolled in day care center, certified family child care home, other licensed facility which cares for children, preschool programs, and public and private primary and secondary schools.)

Name of Child. [redacted] Birthdate: [redacted]
(Last) (First) (Middle)

Name of Parent or Guardian. _____

Address: _____
(Street) (City) (State) (Zip code)

DATES IMMUNIZATIONS WERE ADMINISTERED (Month/Day/Year)

Diphtheria, Tetanus, Pertussis* #1 9/3/13 #2 11/18/13 #3 1/20/14 #4 9/29/14 #5 __/__/__

Hib** #1 9/3/13 #2 11/18/13 #3 9/29/14 #4 __/__/__

PCV (Pneumococcal) #1 9/3/13 #2 11/18/13 #3 1/20/14 #4 9/29/14

Polio #1 9/3/13 #2 11/18/13 #3 1/20/14 #4 __/__/__

Hepatitis B*** #1 4/25/13 #2 9/3/13 #3 1/2014 or **Adult dose*** #1 __/__/__ #2 __/__/__

MMR (Measles, Mumps, Rubella) #1 9/29/14 #2 __/__/__

Varicella #1 9/29/14 #2 __/__/__ or child has had **chickenpox or zoster disease (X)** ___

Jap #1 __/__/__ or **Td** #1 __/__/__ **Meningococcal** #1 __/__/__

*DTaP, DTP or DT. **Hib not required at 5 years of age or more. ***Alternative two dose series of approved adult hepatitis B vaccine for adolescents 11 through 15 years of age.

This child is current for immunizations until 5/25/17 (14 days after the next shot is due) after which this certificate is no longer valid, and a new certificate must be obtained.

I CERTIFY THAT THE ABOVE NAMED CHILD HAS RECEIVED IMMUNIZATIONS AS STIPULATED ABOVE

AD Wells MD/APChaparro(RN) 4/28/16
(Signature of physician, APRN, PA, pharmacist, LHD administrator, or nurse designee) (Date)

CHD
(Name of Office or Licensed Healthcare Facility)

This certificate should be presented to the school or facility in which the child intends to enroll and should be retained by the school or facility and filed with the child's health record.

Kentucky UNBRIDLED SPIRIT

PP-D-23C (Rev. 05/2010)

Agency: [redacted] Site: [redacted]

Class: B Size= 16

General Information

Child Name: [redacted] Child ID: [redacted] DOB: [redacted]

Age: 3y / 8m / 9d Gender: Female

Immunizations

	First	Second	Third	Fourth	Fifth	Next Shot Due	Waiver
Polio	09-03-2013	11-18-2013	01-20-2014		N/A	04-08-2022	
DTAP	09-03-2013	11-18-2013	01-20-2014	08-29-2014		09-11-2025	
MMR	09-29-2014		N/A	N/A	N/A	09-11-2025	
HIB	09-03-2013	11-18-2013	09-29-2014		N/A	12-16-2022	
HepatitisB	04-25-2013	08-03-2013	01-20-2014		N/A	04-08-2022	
Varicella	09-29-2014					01-11-2018	
HepatitisA					N/A	07-19-2021	
Pneumococcal	09-03-2013	11-18-2013	01-20-2014	08-29-2014	N/A	COMPLETED	
Rotavirus					N/A	06-14-2013	

Child is up-to-date on all immunizations appropriate for his/her age: Yes (until 05-14-2013)

Child has received all immunizations possible at this time

Child Met State's guidelines for an exemption from immunizations

Comments

Comments

Next Certification Date: 05-27-2017

Immunization at Enrollment (Health History)

*Is child up-to-date on all immunizations appropriate for his/her age ?: Yes

*Has child received all immunizations possible at this time but has not receive all immunizations appropriate for his/her age ?:

KDE/DDS

KDESHS002

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time period to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE ALL IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: [redacted] Gender: (M) F Grade: Pre-K

Date of Birth: [redacted] Age: 3 yrs 11 months Preferred Language: English

Parent or Guardian Name:

RECORD OF IMMUNIZATIONS TO BE AFFIXED OR IMMUNIZATION CERTIFICATE FORM, EPID 230.

MEDICAL HISTORY

Allergies: NKA

Current Prescribed Medications to be taken daily at school: None

Significant Historical Information: Previously Well/Has Asthma

SCREENING RESULTS:

Height: ___ ft ___ inches 3ft 2 in Weight 31# BMI: ___ BMI%: ___ BP: ___

Vision	Right 20/ ___	Passed ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐		
	Left 20/ ___	Failed ☐	Hearing - Left	Passed ☐	Failed ☐	Referred ☐		
		Referred ☐ Uncooperative					Uncooperative	

Optional: Hct/HGB: 11.0 Lead: ___ Urinalysis: Unable

Gross dental (teeth and gums)	☑ Normal ☐ Abnormal		Refer/Tx:
Ht. Circ/pulse	☑ Normal ☐ Abnormal		Refer/Tx:
Eyes/Ears/Nose/Throat	☑ Normal ☐ Abnormal		Refer/Tx:
Chest/Lungs/Heart	☑ Normal ☐ Abnormal		Refer/Tx:
Abdomen	☑ Normal ☐ Abnormal		Refer/Tx:
Scoliosis assessment	☑ Normal ☐ Abnormal		Refer/Tx:

(Over)

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☑ Social/Behavioral ☑ Cognitive

Specify: ADHD

☐ This child has a health condition that may require emergency action at school [redacted] allergies. Specify below.

[redacted]

Recommendations (Attach additional sheet if necessary): [redacted]

(Please Check One)

☐ This child may participate fully in school activities including physical education

☐ This child may participate in school activities including physical education with the following restriction/accommodation:

(Specify reason and restriction)

ANTICIPATORY GUIDELINES

Discussed with/to teacher given

☑ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communicate with teachers

☐ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☑ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☑ ORAL HEALTH
- Regular dentist visit
- Brushing/Flossing
- Fluoride

☐ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: ADHD, Child Autism

Signed: [signature] Date: 6/30/14

Physician/Nurse Practitioner/WIC/SDI Provider

Address:

Chad M. Tate, M.D.
306 Hospital Drive, Suite 201
So Williamson, KY 41503
606-237-1766
606-237-1790 (fax)

Received
3-14-16

[redacted]

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school within one (1) year prior to entry to ninth grade. Local school boards may extend this time not to exceed two (2) months. (704 KAR 4:020)
PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: [redacted] Gender: M F Grade: _____

Date of Birth: [redacted] Age: 4 yrs 8 months Preferred Language: _____

Parent or Guardian Name: _____

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 250.

MEDICAL HISTORY

Allergies: NKA

Current Prescribed Medications to be taken daily at school: NKA

Significant Historical Information: NKA

SCREENING RESULTS

Height: 3 ft 10 inches 42 Weight 41 BMI: 16.3 BMI%: _____ BP: 90/52

Vision	Right 20/ _____	Passed ☐	Hearing – Right	Passed ☑	Failed ☐	Referred ☐
	Left 20/ _____	Failed ☐	Hearing – Left	Passed ☑	Failed ☐	Referred ☐
		Referred ☐				

Optional: HgbHGB: 13.3 / 13.4 Lead: <3.3 µg/dL Pb Urinalysis: Pkg

Gross dental (teeth and gums)	☑ Normal ☐ Abnormal		Refer To:
Head/Cephalia	☑ Normal ☐ Abnormal		Refer To:
Eyes/Ears/Nose/Throat	☑ Normal ☐ Abnormal		Refer To:
Chest/Lungs/Heart	☑ Normal ☐ Abnormal		Refer To:
Abdomen	☑ Normal ☐ Abnormal		Refer To:
Scoliosis assessment	☐ Normal ☐ Abnormal		Refer To:

The child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

(Over)

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

Recommendations (Attach additional sheet if necessary):

(Please Check One)

☑ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities and the associated physical education with the following restriction/modification.

(Specify reason and restriction):

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☑ SCHOOL READINESS
- Establish routines
- After school commitments
- Friends
- Bullying
- Communicate with teachers

☑ MENTAL HEALTH
- Family time
- Anger management
- Discipline for teaching not punishment
- Limit TV, computer

☑ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet, including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☑ ORAL HEALTH
- Regular dentist visits
- Brushing/Flossing
- Fluoride

☐ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations:

Signed: _____ Physician/APRN/PA/ETSD/Provider Date: 8/9/11

Address: _____ Telephone: _____

Kentucky Department of Education

Agency: [redacted] Site: [redacted]
Class: B Size: 18

Child Name: [redacted] Child ID: [redacted] DOB: [redacted]
Age: 5y 2m 18d Gender: Male

Doctor Information

Doctor/Clinic Name:	Physician for Children @ Pikeville	Phone #:	(606) 437 0120
Doctor Address:	1339 Mayo Trail	Doctor Fax:	

Dental Information

Dentist/Clinic Name:	Hyden, Seth	Phone #:	(606)-555-6555
Dentist Address:	15 Grace Drive	Dentist Fax:	

Insurance Information

Insurance/Group #:	Anthem Blue cross / Blue shield / 321376	Policy #:	PAS0047eb093
Comments			

Dental Coverage: Yes Coventry Cares Policy#044567584

WIC	Food Stamps	Surplus Food
No	No	No

Primary Reason for not Receiving Treatment

Medical & Dental Home

Child Receives Medical Services Through:

Ongoing source of Continuous, Accessible Medical Care Yes (Medical Home)		Child receives an ongoing source of Continuous Dental Care (Dental Home)	Yes
Indian Health Services	No	Is the child up-to-date on a schedule of age-appropriate Preventive and Primary Health Care including all appropriate tests and physical exams?	Yes
Migrant Community Health Center	No	Up To Date at Enrollment (Based on EPSDT schedule)	Yes
Program verification date:	10-28-2015	Health Care Prof. verification date:	09-04-2015

Critical Notes

Health History Notes:

Medication provided at home

Medication provided at site

Critical Health Notes:

New Allergies:

Last Allergy Screening: --

Physical Date: 09-04-2015

Was Physical a EHDP exam

Medical Emergencies (Next Due: No Date Set)

Type	Date
Performed By	Follow Up Status
Concern/Diagnosis	Diagnosis date

Previous Results

Vision (Next Due: 09-10-2017)

Performed By	Stat	Result Left/Right	Exam Date	Treatment
Treatment Status	No Problem Suspected	20/30 - 20/30 (Screening)	09-10-2016 4y 9m 29d	
Referred To		Comments	tested with glasses	

[redacted]

HLS 8084

MISCELLANEOUS SCREENINGS AND LABORATORY TESTS PERFORMED ON-SITE

[redacted]

Enter provider's initials in same block with test result

DOB [redacted] HH# 548

Tests/Collection date		11-8-12	11-13	[illegible]	[illegible]	
Height		[illegible]	[illegible]	[illegible]	[illegible]	
Weight		45-1/4	[illegible]	[illegible]	45 [illegible]	
Head Circumference		18	18 [illegible]	[illegible]	[illegible]	
BMI		19.56	[illegible]	19.5	[illegible]	
Blood Pressure					[illegible]	
Temperature					[illegible]	
Pulse					[illegible]	
Respiration					[illegible]	
Vision					[illegible]	
Hearing					[illegible]	
Collection Time		12:10 PM	[illegible]	[illegible]	[illegible]	
ALT						
AST						
Fecal Occult Blood						
Glucose	mg/dL	[illegible]				
Hemoglobin	g/dL	11.4 AY				
Hematocrit	%					
Infant						
Lead	µg/dL					
Sickle Cell						
Streptococcus, Group A						
Urine Dipstick: Albumin	mg/dL					
Bilirubin						
Ketones	mg/dL					
Specific gravity						
Blood	mg/dL					
pH						
protein	mg/dL					
urobilinogen	mg/dL					
nitrite						
leukocytes						
Lipids (record results on specific row): Cholesterol	mg/dL					
Triglycerides	mg/dL					
HDL	mg/dL					
LDL	mg/dL					
Non HDL	mg/dL					
TC/HDL						

[illegible] (Rev. [illegible])

Hearing (Next Due: 10-10-2017)

Performed By	Staff	Result Left/Right	Exam Date	Treatment
Treatment Status	No Problem Suspected	20 20 (Screening)	10-10-2016 4y / 11m / 22d	
Referred To	Comments			
Previous Results	08-20-2013 (Age At Exam) 4y / 11m / 2d Performed By Staff (R) Re-Screen Next Due 10-19-2016 Screening			

Anemia Screening (Next Due: 08-19-2016)

Performed By	Physician	Result	Exam Date	Treatment
HGB	No Problem Suspected		08-18-2015 4y / 10m / 3d	
HCT				
Iron Prescribed				
Referred To	Comments			
Previous Results				

Asthma Screening (Next Due: No Date Set)

Performed By	Result	Exam Date	Treatment
Treatment Status		y / m / d	
Referred To	Comments		
Previous Results			

Diabetes Screening (Next Due: No Date Set)

Performed By	Result	Exam Date	Treatment
Treatment Status		y / m / d	
Referred To	Comments		
Previous Results			

General Health (Next Due: 08-19-2017)

Performed By	Collaborative Agency	Result	Exam Date	Treatment
Blood Pressure	Normal	82/50	08-18-2015 4y / 10m / 0d	
Sickle Cell			y / m / d	
Fluoride Prescribed			y / m / d	
Urinalysis			y / m / d	
Cholesterol			y / m / d	
Treatment Status	No Problem Suspected			
Referred To	Comments			
Previous Results				

Lead Screening (Next Due: 11-07-2017)

Performed By	Staff	Result	Exam Date	Treatment
Lead Screen	(Screening)		11-07-2016 5y / 0m / 9d	
Treatment Status	Refusal/Not Needed			
Referred To	Comments			
Previous Results	08-20-2013 (Age At Exam) 4y / 0m / 5d Performed By Staff (R) 2mo Normal PASS (Assessment) Next Due 08-20-2014 (ITS) No Problem Suspected			

KID 7 3DA [illegible]

11-2-16 [redacted] 4

PREVENTATIVE HEALTH CARE EXAMINATION FORM

All local boards of education shall require a preventative health care examination of each child first entering a Kentucky public school within a period of twelve (12) months prior to initial admission to school and within one (1) year prior to entry to sixth grade. Local school boards may extend this time not to exceed two (2) months. (702 KAR 1:160)

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name: [redacted] Gender: (M) F Grade: Headstart

Date of Birth: [redacted] Age: 5 yrs ____ months Preferred Language: ________

Parent or Guardian Name: ________

RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM EPID 230.

MEDICAL HISTORY

Allergies: Ø

Current Prescribed Medications to be taken daily at school: Ritalin 10mg tid

Significant Historical Information: ADD / ADHD Anxiety

SCREENING RESULTS:

Height ____ ft 44¼ inches Weight 44lbs BMI: 17.6 BMI% 90% (Obese)

Vision	Right 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☒	Failed ☐	Referred ☐
	Left 20/____		Hearing – Left	Passed ☒	Failed ☐	Referred ☐

Optional: Hgb/HCT: N/A (Names pictures) Lead: (circled) Urinalysis: N/A

Oral Health (teeth and gums)	☒ Normal	☐ Abnormal ________	Refer/Tx: ________
Head/Scalp/Skin	☒ Normal	☐ Abnormal ________	Refer/Tx: ________
Eyes/Ears/Nose/Throat	☒ Normal	☐ Abnormal ________	Refer/Tx: ________
Chest/Lungs/Heart	☒ Normal	☐ Abnormal ________	Refer/Tx: ________
Abdomen	☒ Normal	☐ Abnormal ________	Refer/Tx: ________
Scoliosis assessment	☒ Normal	☐ Abnormal ________	Refer/Tx: ________

(Over)

This child has the following restrictions that may interfere with educational experience:

☐ Vision ☐ Hearing ☒ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child may have life-threatening emergency reaction to stimuli, e.g. seizures, allergies. Specify below.

Recommendations (Attach additional sheets if necessary): _____

(Please Check One)

☒ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction(s) applied:

(Specify reason and restriction) _____

ANTICIPATORY GUIDELINES

Discussed and/or handout given

☒ SCHOOL READINESS
- Establish routines
- After-school care/activities
- Friends
- Bullying
- Communication with teachers

☒ MENTAL HEALTH
- Family life
- Anger management
- Discipline for teaching appropriate behavior
- Limit TV, computer

☒ NUTRITION AND PHYSICAL ACTIVITY
- Healthy weight
- Well-balanced diet including breakfast
- Fruits, vegetables, whole grains, dairy
- 60 minutes of exercise/day

☒ ORAL HEALTH
- Regular dentist visit
- Brushing/flossing
- Fluoride

☒ SAFETY
- Sexual safety
- Pedestrian safety
- Safety helmets
- Swimming safety
- Fire escape plan
- Smoke/carbon monoxide detectors
- Guns
- Sun
- Appropriately restrained in all vehicles

Additional comments or recommendations: _____

Signed: _____ Physician/APRN/PA/RD/LPC Provider

Date: 11-1-16

Address: _____

Telephone: 789-2520

Previous Results	07-27-2015 (Age At Exam) 3y / 9m / 22d Performed By Staff (R) PassedNext Due 07-27-2016 (TS) No Problem Suspected 12-03-2014 (Age At Exam) 3y / 1m / 28d Performed By Staff (R) PassedNext Due 12-03-2015 (TS) No Problem Suspected

Diabetes Screening (Next Due: No Date Set)

Performed By		Result	Exam Date	Treatment
Treatment Status				
			y / m / d	
Referred To	Comments			
Previous Results				

General Health (Next Due: 10-16-2017)

Performed By	Physician	Result	Exam Date	Treatment
Blood Pressure	Normal	88/46	10-16-2015 4y / 6m / 1d	
Sickle Cell			y / m / d	
Fluoride Prescribed			y / m / d	
Urinalysis			y / m / d	
Cholesterol			y / m / d	

Treatment Status	No Problem Suspected
Referred To	Comments
Previous Results	11-13-2014 (Age At Exam) 3y / 1m / 8d Performed By Collaborative Agency Blood Pressure Normal Blood Result 102/64 (TS) No Problem Suspected Next Due 11-13-2016

Lead Screening (Next Due: 07/14/2017)

Performed By	Staff	Result	Exam Date	Treatment
Lead Screen	12mo Normal	passed (Assessment)	07/14/2016 4y / 9m / 9d	

Treatment Status	No Problem Suspected		
Referred To		Comments	
Previous Results	07-27-2015 (Age At Exam) 3y / 9m / 22d Performed By Staff (R) 12mo Normal Passed (Assessment) Next Due 07-27-2016 (TS) No Problem Suspected		
	12-03-2014 (Age At Exam) 3y / 1m / 28d Performed By Staff (R) 12mo Normal Passed (Assessment) Next Due 12-03-2015 (TS) No Problem Suspected		
	11-21-2014 (Age At Exam) 3y / 1m / 16d Performed By Collaborative Agency (R) 24mo Normal 1 (Screening) Next Due 11-21-2016 (TS) No Problem Suspected		

Physical (Next Due: 10-16-2016)

Performed By	Physician			Exam Date	10/16/2015 4y / 0m / 11d
Posture/Gait	Normal	General Appearance	Normal	Speech	Normal
Head	Normal	Nose	Normal	Teeth	Normal
Glands	Normal	Heart	Normal	Lungs	Normal
Bones/Joints/Muscle	Normal	Abdomen	Normal	Genitalia	Normal
Skin	Normal	Back	Normal	Other	Normal
Treatment Status	No Problem Suspected			Specify	
Referred To		Treatment			
Well-Baby Check?		Intervals			
Comments					

KDE088 Kentucky Eye Examination Form for Scr Entry KDE581

KRS 156.160 (1)(g) requires proof of a vision examination by an optometrist or ophthalmologist. This evidence shall be submitted to the school no l ihan January 1 of the firs: year that a three (3), four (4), five (5) or six (6) year old child is enrolled in public school, public preschool, or Head Start program).

PLEASE COMPLETE THE IDENTIFYING INFORMATION

Date of student's enrollment: _____ Date of Vision Examination: 12/29/15

IDENTIFYING INFORMATION

Student Name: [redacted]

Date of Birth: [redacted]

Parent or Guardian Name: _____

CASE HISTORY

Date of Exam: 12/29/15

Ocular History: Normal or Positive for: _____

Medical History: Normal or Positive for: _____

Drug Allergies: NKDA or Allergic to: _____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☒ Glaucoma ☐ Diabetes

Other: _____

Other Pertinent Information: _____

Retinoscopy with cycloplegic? (Please indicate one.) ☒ YES ☐ NO

	OD	OS
Uncorrected Acuity	20/40	20/40
Best Corrected Acuity	20/	20/

Type of Examination	Normal	Abnormal	Notable to Assess
External Health (eye and adnexa)	✓		
Internal Health (media, lens, fundus, etc)	✓		
Neurological Integrity (pupils)	✓		
Binocular Function (stereopsis)			✓
Accommodation and Convergence			✓
Color Vision	✓		

Diagnosis:

☒ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other: _____

Recommendations:

1. Glasses prescribed: ☐ YES ☒ NO
2. _____
3. _____

Age appropriate and suggested additional guidance/health assessment(s):

- ☐ Educate (parents/patients) about eye/vision disorders and related vision care
- ☐ Counsel parents/patients regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed: _____ Date: 10/19/16

(Optometrist/Ophthalmologist)

Address: 4819 South Main Street Telephone: 606 432-7009

Pikeville, KY 41501

Agency: [redacted] Site: [redacted]
Class: B Size: 17

Child Name: [redacted] Child ID: [redacted] DOB: [redacted]
Age: 4y / 6m / 1d Gender: Female

Doctor Information

Doctor/Clinic Name:	File Cloud	Phone #:	(408)-737-7755
Doctor Address:	306 Hospital Drive Suite #201	Doctor Fax:	

Dentist Information

Dentist/Clinic Name:	Nanagh, Josh	Phone #:	(925)-422-2773
Dentist Address:	126 Trivelle Drive Ste#201 Duplex Building	Dentist Fax:	

Insurance Information

Insurance/Group #:	Anthem blue cross / blue shield	Policy #:	

Comments

Dental Coverage:	WIC	Food Stamps	Surplus Food
	No	No	No

Primary Reason for not Receiving Treatment

Medical & Dental Home

Child Receives Medical Services Through:

Ongoing source of Continuous, Accessible Medical Care (Medical Home)	No	Child receives an ongoing source of Continuous Dental Care (Dental Home)	
Indian Health Services	No	Is the child up to date on a schedule of age appropriate Preventive and Primary Health Care including all appropriate tests and physical exams?	
Migrant Community Health Center	No	Up To Date at Enrollment (Based on EPSDT schedule)	No
Program verification date:	08-10-2016	Health Care Prof. verification date:	08-10-2016

Critical Notes

Health History Notes:

Medication provided at home:

Medication provided at site:

Critical Health Notes:

New Allergies:

Last Allergy Screening: --

Physical Date: 08-10-2016 Was Physical a SHOP exam

Medical Emergencies (Next Due: No Date Set)

Type		Date	
Performed By		Follow Up Status	
Concern/Diagnosis		Diagnosis date	
Previous Results			

Vision (Next Due: 10-10-2017)

Performed By	Physician	Result Left/Right		Exam Date	Treatment
Treatment Status	No Problem Suspected	20/40	20/40 (Assessment)	10-10-2016	
Referred To		Comments			

Child Seen Completed

Head Start Developmental Screening Results

Program: [redacted]

Child's Name: [redacted] Child's DOB [redacted]

Staff Initials verify that the parent has been notified in some home about screening results within 10 days of the date completed.

Brigance: Self-Help & Social Emotional (Teacher Report):

Self-Help

☐ Below Average ☐ Average ☐ Above Average

Social Emotional

☐ Below Average ☐ Average ☐ Above Average

Screening Completion Date: _____ Staff Initials: _____

Initial Screening

Brigance: *(Cognitive, Motor, Language)*

Initial Screen: Overall Score

☐ Above Average ☐ Below Average

☑ Average ☐ CNT *(Could Not Test)*

Screening Completion Date: 7-14-16

Staff Initials: [redacted]

Speech: Fluharty 2

(Tool Used)

☑ Pass ☐ Potential Delay/Fail ☐ CNT *(Could Not Test)*

Screening Completion Date: 7-14-16

Staff Initials: [redacted]

Hearing: [redacted]

Screener Signature:

Completed at 20db

Frequency	1000Hz	2000Hz	4000Hz
Left	✓	✓	✓
Right	✓	✓	✓

☐ Pass ☐ Fail ☐ CNT *(Could Not Test)*

Screening Completion Date: 7-13-16

Staff Initials: [redacted]

Vision: *(Symbols for 20 Foot Vision Chart)* [redacted]

Screener Signature:

Right Eye	20/
Left Eye	20/

☑ Pass ☐ Fail ☐ CNT *(Could Not Test)*

Screening Completion Date: 7-13-16

Staff Initials: [redacted]

Rescreen

Brigance Rescreen: *(within 30 days if initial screen is "Below" or "CNT")*

Cognitive: ☐ Above Average ☐ Below Average

☐ Average ☐ CNT *(Could Not Test)*

Motor: ☐ Above Average ☐ Below Average

☐ Average ☐ CNT *(Could Not Test)*

Screening Completion Date: _____

Staff Initials: _____

Speech Rescreen: _____

(Tool Used)

☐ Pass ☐ Potential Delay/Fail ☐ CNT *(Could Not Test)*

Screening Completion Date: _____

Staff Initials: _____

Hearing Rescreen: *(within 30 days if initial screen is "Refer" or "CNT")*

Screener Signature: _____

Completed at 20db

Frequency	1000Hz	2000Hz	4000Hz
Left			
Right			

☐ Pass ☐ Fail ☐ CNT *(Could Not Test)*

☐ *Refer for further testing*

Screening Completion Date: _____

Staff Initials: _____

Vision Rescreen: *(Symbols for 20 Foot Vision Chart)*

Screener Signature: _____

Right Eye	20/
Left Eye	20/

☐ Pass ☐ Fail ☐ CNT *(Could Not Test)*

☐ *Refer for further testing*

Screening Completion Date: _____

Staff Initials: _____

Head Start
Notification of
Growth Assessment

Date of Measure 8-23-16

Name [redacted] Classroom [redacted]

Height Measure 36 inches

Weight Measure 25 lbs

BMI stands for ***Body Mass Index***. ***BMI*** is calculated from weight and height measurements and is used to judge whether an individual's weight is appropriate for their height.

There are four categories in which children fall according to their ***BMI***. They are listed below. Your child falls into the following category: (Staff, please circle or highlight the category in which the child falls.)

1. ***Underweight:*** At or below the 5th %.
2. ***Normal:*** Above the 5th% and below the 85th%
3. ***At Risk of Overweight:*** Between the 85th % and 95th %
4. ***Overweight:*** At or above the 95th%

If you have any questions, please contact me. Head Start also has a Registered Dietitian, Lori Howard, who will be happy to talk to you about any concerns that you have. Her number is 789-1600

Staff Signature [redacted] Date: 8-31-16

Staff signature verifies that parent/caregiver has been notified of growth assessment results.

Category: Assessment, Attendance, Dental

Service Type: Adult Education, Assistance to families of incarcerated individuals, Child abuse and neglect services

Case Notes Date From: 07-01-2016 To: 12-06-2016

Filter | View All

Family Name: [redacted]
Family ID: [redacted]
Birthdate: [redacted]

Case Notes Information

Case Note Date(ID) Submitted By	Category	Service Type	Case Note
11-01-2016 (97543) [redacted]	Education	Other	FSW has sent home with the information for the Baby Shower that is scheduled this month for new parents.
11-04-2016 (97810) [redacted]	Growth		FSW sending home a permission slip to allow the child to ride the bus to get an eye exam with Dr. Nordin on November 14th.
10-12-2016 (95091) [redacted]	Dental		FSW SENT HOME LETTER TO MOM THAT [redacted] NEEDS A VISION AND DENTAL EXAM.
10-11-2016 (95329) [redacted]	Education		FSW HAS SENT HALLOWEEN SAFETY TIPS HOME FOR ALL KIDS
10-04-2016 (94733) [redacted]	Dental		FSW SENT HOME NOTICE TO THE CHILD'S PARENT TO GET A NEW DENTAL EXAM FOR BOTH [redacted]
09-22-2016 (94522) [redacted]	Health		FSW SENT PARENT A NOTICE THAT CHILD NEEDS A VISON AND DENTAL EXAM. ALSO NEEDS A BLOOD PRESSURE.
08-23-2016 (93137) [redacted]	Growth		FSW SENT NOTICE OF GROWTH ASSMT TO PARENT FOR OVER WEIGHT AND COPY OF HEALTHY EATING TIPS.

Teacher's Observation of Child Health

Child's Name [redacted] Teacher [redacted]

Classroom B Date of Observation 1st 9-25-16 2nd

Does this child complain of or demonstrate any of the following more severely or more often than most of his/her classmates?

	1 Y	1 N	2 Y	2 N
Tires Easily		/		
Frequently Sleepy		/		
Inactive		/		
Shortness of Breath with Exercise		/		
Unintelligible Speech		/		
Hearing Difficulties		/		
Discharge or Drainage from Ears		/		
Continuous Runny Nose		/		
Frequent Nose Picking or Rubbing		/		
Seizures or Spells		/		
Mouth or Tooth Pain		/		
Headaches		/		
Clumsiness		/		
Poor Vision Wears glasses		/		
Eyes Cross or Turn Out		/		

	1 Y	1 N	2 Y	2 N
Poor Posture, Limp / Abnormal Gait		✓		
Poor Nutrition or Eating Habits		✓		
Poor Hygiene		✓		
Skin Rash / Skin Sores		✓		
Frequent Scratching		✓		
Pale or Sallow Skin		✓		
Red, Runny or Itchy Eyes		✓		
Stomachaches		✓		
Vomiting		✓		
Frequent Urination		✓		
Wet Pants		✓		
Soil Self with Bowel Movements		✓		
Coughing		✓		
Wheezing		✓		
Diarrhea		✓		

What is your opinion of this child's Health?

Perfectly Healthy ✓ Specific Problem(s) as noted but Generally Healthy

Not in Good Health

It is required that you document how you are addressing any item(s) marked YES

Victor wears glasses and has difficulty [redacted]

Child's Name [redacted] Teacher [redacted]

Classroom [redacted] Date of Observation 1st 9-1-16 2nd _____

Does this child complain of or demonstrate any of the following more severely or more often than most of his/her classmates?

	1		2	
	Y	N	Y	N
Tires Easily		✓		
Frequently Sleepy		✓		
Inactive		✓		
Shortness of Breath with Exercise		✓		
Unintelligible Speech	✓			
Hearing Difficulties		✓		
Discharge or Drainage from Ears		✓		
Continuous Runny Nose		✓		
Frequent Nose Picking or Rubbing		✓		
Seizures or Spells		✓		
Mouth or Tooth Pain		✓		
Headaches		✓		
Clumsiness		✓		
Poor Vision		✓		
Eyes Cross or Turn Out		✓		

	1		2	
	Y	N	Y	N
Poor Posture, Limp / Abnormal Gait		✓		
Poor Nutrition or Eating Habits		✓		
Poor Hygiene		✓		
Skin Rash / Skin Sores		✓		
Frequent Scratching		✓		
Pale or Sallow Skin		✓		
Red, Runny or Itchy Eyes		✓		
Stomachaches		✓		
Vomiting		✓		
Frequent Urination		✓		
Wet Pants		✓		
Soil Self with Bowel Movements		✓		
Coughing		✓		
Wheezing		✓		
Diarrhea		✓		

What is your opinion of this child's Health?

Perfectly Healthy ☐ Specific Problem(s) as noted but Generally Healthy ☐

Not In Good Health ☐

It is required that you document how you are addressing any item(s) marked YES.

* Suspected Speech problem. Speech Therapist [redacted] will do an evaluation.

Screening Date	Age at Screening	Performed By	Instrument	Result	Decision	Score	Re-Screen/Due Date	Referral Needed
09-20-2015	3y / 11m / 16d	Flanary	Brigance (36 - 60 mo)	Average	OK	7.00		No
Comments:								
06-10-2015	3y / 8m / 6d	Parent	Brigance (36 - 60 mo)	Passed	OK			No
Comments:								

Speech & Language - HS (Next Due: Pending)

Screening Date	Age at Screening	Performed By	Instrument	Result	Decision	Score	Re-Screen/Due Date	Referral Needed
06-10-2015	3y / 8m / 6d	Sword	Dial - 4	Passed	OK	13.00		No
Comments:								

Follow-Up (HS)

SRT Date | Evaluation Date | Referral Date | Total Score: 74

Performed By	Staff	Result Left/Right	20/20/20 / 20/20/20	Exam Date	08-18-2016	Next Exam Due	08-18-2017
				Age At Exam:	4y / 10m / 14d		
Treatment Status	No Problem Suspected	Treatment Received					
Referred To		Comments				Exam Type	Screening
Performed By	Staff	Result Left/Right	20/20/20 / 20/20/20	Exam Date	06-10-2015	Next Exam Due	06-10-2016
				Age At Exam:	3y / 8m / 6d		
Treatment Status	No Problem Suspected	Treatment Received					
Referred To		Comments		prescreening		Exam Type	Screening

Performed By	Staff	Result Left/Right	25 / 25	Exam Date	08-18-2016	Next Exam Due	08-18-2017
				Age At Exam:	4y / 10m / 14d		

OAS/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

Kentucky law, KRS 156.160(5), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: [redacted] (Last / First / Middle)

Birth date: [redacted] Gender: ☐ 0 Male ☒ 0 Female

Parent or Guardian: ____ (Name) ____ (Relationship)

Address: ____ City: ____

Phone Number: ____ School: ____

Date of Exam/Screening 2-17-16

Test Type (check one)

☐ Screening

☒ Exam

Screener's Name: Dr. Alan Seth Hylden

Screener's Address: 38 Grace Drive, Prestonsburg, KY 41653

Phone Number: (606) 886-6565 Screening Date: 2-17-16

Screener's Signature: [signature]

Professional affiliation: (Please check one)

☒ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ LHD Registered Nurse with KIDS Smiles training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☒ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☒ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☒ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☒ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care

NOTE: Comment required if marked.

Comments:

OH-12

Previous Results	04-08-2016 (Age At Exam) 4y / 0m / 12c **Performed By** Collaborative Agency **Posture/Gait** Normal **General Appearance** Normal **Speech** Normal **Head** Normal **Nose** Normal **Teeth** Normal **Glands** Normal **Heart** Normal **Lungs** Normal **Abdomen** Normal **Genitalia** Normal **Bones/Joints/Muscle** Normal **Skin** Normal **Back** Normal **Other** Abnormal **Specify** ear canal red(TS) No Problem Suspected **Next Due** 05-08-2017 **Referred** No 04-23-2015 (Age At Exam) 3y / 0m / 27c **Performed By** Registered Nurse Practitioner **Posture/Gait** Normal **General Appearance** Normal **Speech** Normal **Head** Normal **Nose** Normal **Teeth** Normal **Glands** Normal **Heart** Normal **Lungs** Normal **Abdomen** Normal **Genitalia** Normal **Bones/Joints/Muscle** Normal **Skin** Normal **Back** Normal **Other** Normal(TS) No Problem Suspected **Next Due** 04-23-2016 **Referred** No

Dental (Next Due: 02-17-2017)

Dental Chart

Performed By	Dentist	Exam Date (Age at Exam)	02-17-2016 3y / 10m / 21c
Is this a Dental Exam?	Yes **Is the exam part of the Well-Baby check?** No	**Intervals**	
Dental Needs Identified:	Cleaning and Fluoride		
Treatment Status:	Complete/No Further Treatment	**Date Completed**	02-17-2016

If treatment needed but was not received, please specify the primary reason

Dental Follow-Up (If not complete - please explain):

Previous Results	02-25-2015 (Age At Exam) 2y / 10m / 25c **Dental Exam Performed By** Dentist (DNI) Cleaning and Fluoride (TS) No Treatment Needed 02-25-2015 **Next Due** 02-25-2016

Tobacco Assessment

Child Exposed to Second Hand Smoke?	No	**Counseled about/referred for Tobacco Use Prevention/Cessation?**	No

OAS/DSS

Kentucky Dental Screening/Examination Form for School Entry

KDESHS005

Kentucky law, KRS 156.160(1), requires proof of a dental screening or examination by a dentist, dental hygienist, physician, registered nurse, advanced registered nurse practitioner, or physician assistant. This evidence shall be presented to the school no later than January 1 of the first year that a five (5) or six (6) year old is enrolled in public school.

Student Name: [redacted] (Last / First / Middle)

Birth date: [redacted] Gender: ☐ 0 Male ☐ 1 Female

Parent or Guardian: _____ (Name / Relationship)

Address: _____ City: _____

Phone Number: _____ School: _____

Date of Exam/Screening ___/___/___

Test Type (check one)

☐ Screening

☐ Exam

Screener's Name: Joshua Raleigh DMD

Screener's Address: 126 Trivette Dr Ste 201 Pikeville, KY 41501

Phone Number: (606-432-2773 Screening Date: _____

Screener's Signature: Joshua Raleigh DMD

Professional affiliation: (Please check one)

☐ Dentist ☐ Dental Hygienist

☐ Physician Assistant ☐ LHD Registered Nurse with KIDS Smiles training

☐ APRN ☐ Physician

Untreated Decay: (Check one)

☑ 0 No untreated cavities

☐ 1 Untreated cavities

Treated Decay: (Check one)

☑ 0 No treated cavities

☐ 1 Treated cavities

Pattern of Early Childhood Cavities: (Check one)

☑ 0 No Early Childhood Cavities

☐ 1 Early Childhood Cavities Present

Treatment Urgency: (Check one)

☑ 0 No obvious problem

☐ 1 Early dental care needed

☐ 2 Referral for Urgent Care

NOTE: Comment required if marked

Comments:

6 month cleaning scheduled for 4/11/17

OH-12

Previous Results	08-09-2016 (Age At Exam) 3y / 2m / 11d Performed By Staff (R) 09mo Norm: passed (Assessment) Next Due 08-09-2017 (TS) No Problem Suspected

Physical (Next Due: 08-11-2017)

Performed By	Physician			Exam Date	08-11-2016 (Age at Exam) 3y / 2m / 13d
Posture/Gait	Normal	General Appearance	Normal	Speech	Abnormal
Head	Normal	Nose	Normal	Teeth	Abnormal
Glands	Normal	Heart	Normal	Lungs	Normal
Bones/Joints/Muscle	Normal	Abdomen	Normal	Genitalia	Normal
Skin	Normal	Back	Normal	Other	
Treatment Status	No Treatment Needed			Specify	
Referred To		Treatment Intervals			
Well-Baby Check?					
Comments	diazepam, seizures, give meds if seizure goes over 5 minutes, needs PT, OT and speech , has Cerebral Palsy				

Previous Results			
	Dental (Next Due: No Date Set)	Dental Chart	Date of Last Visit - Health History:
Performed By			Exam Date (Age at Exam) y / m / d
Is this a Dental Exam?	Is the exam part of the Well-Baby check?		Intervals
Treatment Status:			Date Completed
If treatment needed but was not received, please specify the primary reason			
Dental Follow-Up (if not complete - please explain):			

Previous Results	
	Tobacco Assessment
Child Exposed to Second Hand Smoke?	Counseled about/referred for Tobacco Use Prevention/Cessation?

Category: Assessment, Attendance, Dental — Service Type: Adult Education, Assistance to families of incarcerated individuals, Child abuse and neglect services — Case Notes Date From: 07-01-2015 To: 12-15-2016 Filter View All

Family Name: [redacted]
Family ID: [redacted]
Birthdate: [redacted]

Case Notes Information

Case Note Date(ID) Submitted By	Category	Service Type	Case Note
11-10-2016 (98345) [redacted]	Parent Involvement	Other	sent flyer home SET THE TABLE FOR SAFETY
11-07-2016 (97770) [redacted]	Health		I was at [redacted] today and was going to check and see if the nurse would check [redacted] blood pressure but she was absent.
11-01-2016 (96746) [redacted]	Health		Spoke with [redacted], I told her I made [redacted] an appointment with the hearing doctor in Prestonsburg. It is Nov. 15th at 9:30 and I will transport them. Will call her later with the time I will be picking her up
09-26-2016 (94104) [redacted]	Growth		Growth assessment results and healthy eating tips will be sent out to the parent/guardian concerning [redacted] height/weight and BMI. A copy of each will also be put in the child's folder.
04-04-2016 (89866) [redacted]	Parent Involvement		I sent letters home about our April parent meeting
03-24-2016 (89468) [redacted]	Dental		Sent letter home telling parents know [redacted] needs Dental updated. She had an appt. in Feb.

Dental Travel Permission

Dear Parent/Guardian:

Your child [redacted] _____ is scheduled for a medical appointment on 10-26-16 __, at 9a.m. a.m./p.m., with Dr. Dr. Neeley ___ , in [redacted] ____ _____ for Dental Exam ___ .

Please check yes or no and sign your name and date below.

____ Yes, He/She may go.

____ No, He/ She may not go.

____ _____ ___ ____

Parent Signature Date

* Each medical trip will need new permission form signed and dated.

Sharon Neeley, D.M.D.
[redacted] Medical Complex
[redacted]

Date: 10-26-16

To Whom It May Concern:

[redacted] was seen in our office on 10-26-16 for a dental checkup.

___ Patient does not need to return to our office.

__✓__ Patient does need to return to ~~our office~~. Pediatric dentist

Reason:
Needs extensive treatment, pt sees Dr. ___
Refer to pediatric dentist for treatment

Thank You,
Sharon Neeley, DMD
Sharon Neeley, DMD

Category: Assessment, Attendance, Dental — Service Type: Adult Education, Assistance to families of incarcerated individuals, Child abuse and neglect services — Case Notes Date From: 07-01-2015 To: 12-06-2016 Filter View All

Family Name: [redacted]
Family ID: [redacted]
Birthdate: [redacted]

Case Notes Information

Case Note Date(ID) Submitted By	Category	Service Type	Case Note
11-29-2016 (99123) [redacted]	Attendance		Mother came into class today and informed me that father had taken child for weekend visit and had taken her to Chile and has refused to return child to mother. Mother is very fearful for the child, said father has a drug addiction and that is way she left him last year. Mother said she was on her way to the county attorney's office to see what she could do about getting her home.
11-21-2016 (98628) [redacted]	Dental		FSW has contacted the mother of the child by phone. The mother informed the FSW that the child does not have a dental appointment follow up yet but will call the FSW with a time and date tomorrow for her appointment
11-04-2016 (97526) [redacted]	Education	Other	FSW has sent home with the information for the Baby Shower that is scheduled this month for new parents
10-12-2016 (95093) [redacted]	Assessment		FSW SENT HOME NOTICE TO PARENT THAT THE CHILD NEEDS A VISION & DENTAL EXAM
10-11-2016 (95313) [redacted]	Education		FSW HAS SENT HALLOWEEN SAFETY TIPS HOME FOR ALL KIDS.