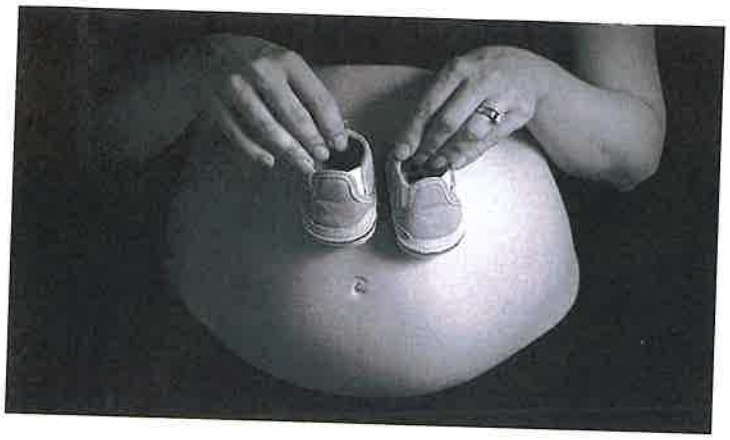
Early Head Start Prenatal Application



The following information needs to be turned in, for your application to be complete.

_____ Application

_____ Prenatal Assessment

_____ Permission and Policy form

_____ HS/EHS Information Sheet

_____ Family Health History

_____ CSBG form

_____ CACFP

_____ Dental form

_____ Copy of your identification

_____ Copy of Insurance Card

_____ Proof of Pregnancy

_____ Proof of income

Early Head Start Prenatal Application

Name: _____ Date of Birth _____

Address: _____

Street City/Town Zip County

Phone Number: _____

Expected Due Date: _____

Marital Status: __ Single, __ Married, __ Divorced, __Separated, __ Living together

Does your family receive any of the following services?

_____ Public Housing Assistance

_____ Child Support/Alimony

_____ Social Security (SSI, SSD, or SSA)

_____ Energy Assistance

Race:

_____ White

_____ African American

_____ American Indian

_____ Native Hawaiian

_____ Biracial/Multiracial

_____ Other _____

Ethnicity: _____ Non-Hispanic _____ Hispanic

I fully understand that the above information is correct to the best of my Knowledge.

_____ _____

Signature Date

HCCAO Early Head Start Prenatal Assessment

Name: _____ Date: _____

What is your expected delivery date? _____

When did you first receive prenatal care? _____

When was your last visit? _____, Next Visit? _____

Who is your Care Provider? _____

What is their phone number? _____

Have you visited a Dentist in the last year? _____

Are you having any dental problems at this time? _____

Do you currently have any complications with your pregnancy?
_____, Previously? _____

Do you have any chronic health problems? _____

Do you have a medical card or other type of insurance? _____

Are you enrolled in WIC? _____

Have you been diagnosed with Anemia? _____

Do you take Pre-natal vitamins? _____

What medications are you taking? _____

Do you use tobacco or drugs? _____ Do you use Alcohol? _____

Do you have a cat? _____

Do you have any nutritional needs? _____ ,If so what are they_____

How is your emotional well being at this time? _____

Do you have any other questions or concerns? _____

No referral needed_____ Referral needed? _____

Date of referral _____ Date referral completed _____

HCCAO Early Head Start Prenatal Application

Permission and Policy Form

Applicants Name: _____ Date of Birth: _____

I give my permission to appear in photographs. _____ yes _____ no

I give my permission for HCCAO Early Head Start to obtain my medical and dental information from doctors, dentists or hospitals where I have been a patient. Also, to obtain information from Job & Family Services for verification of cash assistance, food assistance and child support benefits.

_____ yes _____ no

In the case of an emergency, 911 will be called and you will be transported by EMS to the nearest hospital.

_____ Initials

Grievance Procedure

Grievance /Complaint must be in writing and signed by the person who makes the complaint. Unsigned grievances or complaints will not be answered.

Grievance /complaint should then be submitted to the Director of the Early Childhood Programs. The Director shall have 10 days to resolve the grievance / complaint or present it to the Policy Council for discussion.

I have read and understand the grievance procedure.

_____ _____

Signature Date

_____Signature of parent /guardian (if applicant is a minor.)

H.C.C.A.O. HEAD START / EARLY HEAD START INFORMATION SHEET

Child's Name _____ DOB _____ Age_____

Mother's Name_____ DOB _____ Mother in Home? _____

Father's Name _____DOB _____ Father in HOME? _____

Number in Family _____ Number in Household _____ Is The Child You are Enrolling a Foster Child?____

Do You Have Custody Paper? _____Shared Parenting? _____

Are You a Past Head Start/Early Head Start Parent?_____

Do You Live With Someone Else? _____ Who? _____Are You Homeless? _____

Name The Other Family Members in the Home:

1. _____ Relationship to Child _____ DOB _____
2. _____Relationship to Child _____ DOB _____
3. _____ Relationship to Child _____ DOB _____
4. _____ Relationship to Child _____ DOB _____

Mother's Educational Level _____ Graduated? ____ Father's Educational Level _____ Graduated? _____

Parents/guardian in school or job training? Who?_____ Where? _____ Grad date? _____ Degree?_____

Do You Use Childcare? _____ Who? _____ Do You Have Subsidized Childcare? _____

Was Your Child in Early Head Start? ____Was Your Child in Help Me Grow? ____Do You Receive WIC?_____

Do You or Anyone in Your Family Receive SSI? _____ Who? _____ Do You Receive TANF? ____

Do You Receive OWF? _____ Do You Receive a Food Card? _____ Do You Have Medical Insurance? _____

What Kind of Insurance? _____ Were You a Teen Parent? _____ Are You Pregnant? _____

Parent/Parents in School or Training? _____Are You Employed? _____ Full Time _____ Part Time _____

Are You Employed Less Than One Year? _____ Spouse Employed? _____ Full Time _____Part Time _____

Spouse Employed Less Than a Year? _____ Parent/ Guardian Incarcerated? _____

Does Your Child Have a Disability? _____ IEP _____ Does Parent Have a Disability? _____

Were You Referred by a Child Welfare Agency? _____ Who? _____

Was Your Child on a Waiting List Last Year? _____

Is Anyone in Your Family Receiving Mental Health Counseling or Treatment? _____

Do You Have Any Concerns About Your Child's Behavior? _____What? _____

How Did You Hear About The Head Start Program? _____

*_I hereby certify that all information provided in the application is true and accurate_*

PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____

Family Health History

Child's Name _____ DOB: _____ Gender: _____

Parent / Guardian Names: _____

Family History

1. Have any of the child's direct blood relatives (parents, grandparents, aunts, uncles, brothers and sisters) had any of the following conditions? ____ yes ___ no

If yes, please check the condition (s)

____ Bleeding Conditions ____ Allergies ____ Anemia ____ Asthma

____High Blood Pressure ____ Cancer ____ Diabetes ___ Seizures

____ Heart Problems ____ Mental Illness ____ Mental Retardation

____ Overweight ____ Tuberculosis ____ Sickle Cell ____ SIDS

____ Sickle Cell Trait Other: _____

Child's Medical Record

1. In the last year, has this child had any of the following Conditions? __ Yes __ No

____ Allergies ___ Anemia ___ Asthma ___ Boils ___ Bleeding Conditions ___ Cancer

___ Liver Disease ____ Broken Bones ____ Chicken Pox ____ Diabetes

____ Eczema ___Hives ____ Heart Conditions ____ High Blood Pressure ____ Mumps

____ High Lead ____ Measles ___ Immune System Disease ____ Inherited Disease

____ Seizures ____ Mental Retardation ____ Mental Illness ____ Overweight

____ Pneumonia ____ Sickle Cell Disease ____ Sickle Cell Trait ____ Tubes in ears

____ Tonsils Removed ____ Rheumatic Fever ____ Scarlet Fever Other: _____

2. Is your child receiving treatments for the following conditions? ____ Yes ___ No

___ Anemia ____ Asthma ____ Overweight ____ Hearing Difficulties ____ Diabetes

___ Vision Problems ___ High Lead Levels ____ Other _____

3. Is your child currently taking any medication at home? ____ Yes ____ No

Name of Medication:

Dose: _____ How Often: _____

4. If your child has a health problem, has it been diagnosed by a doctor or health care professional: ____ Yes ____ No, If yes explain:

Family Health History

5. Has your child ever had seizures? ____Yes ____ No

If yes explain:

6. Has your child ever been diagnosed with Asthma? _____ Yes _____ No

If yes explain:

Have they ever been hospitalized for Asthma?

7. Has your child ever had an allergic reaction? _____ Yes _____ No

If yes explain to what and what type of reaction your child had.

8. Has your child ever had problems with the following? _____ Yes ____ No

____ Frequent ear infections ___Frequent sore throats _____ Frequent Fevers

____ Frequent Coughs ____ Frequent Bed Wetting ____ Frequent Chest Pains

____ Frequent Colds ____ Frequent Stomach Aches _____ Problems with Urine

____ Problem with Bowels ____ Problems Eating _____Problems with Teeth

____ Problems Hearing _____ Problems Seeing _____ Eye Problems

_____ Speech Problems _____ Frequent Trouble Sleeping _____ Temper Tantrums

_____ Other Problems: _____

9. Has your child ever been involved in a child abuse or neglect incident or case _____ Yes _____ No If yes, explain:

10. Does your child have any additional conditions that interferes with his/her daily activities? _____Yes ____ No

Behavioral / Activity History

1. Does your child currently have an IEP or IFSP? ___Yes ____ No If so, what school district completed the IEP / IFSP?

Family Health History

Complete the following Chart:

Action or Activity	At what age did your child do the Following:
Sit up without help	
Crawl	
Walk	
Talk	
Feed and Dress Self	
Use the Toilet	
Understand things being said to them	
Follow simple Directions	
Play with toys	
Use Crayons	

Medical Dental Home

1. Do you have a regular Doctor for your child? _____Yes _____ No

Name of Doctor:

Address:

Phone Number:

When did you obtain a doctor for your child? Before or After Enrollment? (Circle One)

2. Do you have a regular Dentist for your child? _____ Yes _____ No

Name of Dentist:

Address:

Phone Number:

3. When did you obtain a dentist for your child? Before or After Enrollment/ (Circle One)
4. Does your child need dental treatment? _____ Yes _____ No
   If yes, has the appointment been made or is it complete?

Parent / Guardian Signature that completed survey: _____

Date Completed: _____

Client Number:	Agency:	Application Date:
	Highland County Community Action Org. Inc.	

Primary Applicant First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male

Household Information:

Household Size:	Family Type	Building Type
	☐ Single Parent/Female ☐ Single Parent/Male ☐ Two-Parent Household ☐ Single Person ☐ Two Adults/No Children ☐ Non-related Adults with children ☐ Multigenerational Household ☐ Other	☐ Mobile Home ☐ Single Family ☐ Multi-family low rise (3 stories or less) ☐ Multi-family high rise (3 stories or more)
Housing Status		
☐ Own ☐ Rent ☐ Other Permanent Housing ☐ Homeless ☐ Other		

Customer Address:

Current Service Address:		Apartment/Lot/Unit Floor:	
Current Mailing Address (if different from above):		Apartment/Lot/Unit Floor:	
City:	State:	Zip Code:	County:
Phone Number:		Email Address:	
Preferred method of contact?			

Primary Applicant Demographic Information:

Ethnicity	Race	Education
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

Additional Household Members:

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

Additional Household Members:

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

First Name	M.I.	Last Name
Social Security Number	**Date of Birth**	**Gender**
___/__/____	__/__/____	☐ Female ☐ Other ☐ Male
Ethnicity	**Race**	**Education**
☐ Hispanic, Latino or Spanish Origins ☐ Not Hispanic, Latino or Spanish Origins	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Unknown/Not-reported ☐ White	☐ Grade 0-8 ☐ Grades 9-12/Non-Graduate ☐ High School Grad/GED ☐ 12+ Some Post-Secondary ☐ Education ☐ 2 or 4 Year College Graduate ☐ Graduate or other post-secondary school
Client Disabled?	**Military Status**	**Is Client a US Citizen?**
☐ Yes	☐ Veteran ☐ Active Military	☐ Yes
Work Status	**Health Insurance Type**	**Non-Cash Benefits**
☐ Employed full-time ☐ Employed part-time ☐ Migrant Seasonal Farm Worker ☐ Unemployed (short-term, 6 months or less) ☐ Unemployed (long-term, more than 6 months) ☐ Unemployed (not in labor force) ☐ Retired ☐ Unknown/not reported ☐ Youth ages 14-24 who are neither working nor in school	☐ Medicaid ☐ Medicare ☐ Private/Employment Based ☐ Self-Insured/Direct Pay ☐ None ☐ State Children's Health Insurance Program ☐ State Health Insurance for Adults	☐ Affordable Care Act Subsidy ☐ Childcare Voucher ☐ Housing Choice Voucher ☐ HUD-VASH ☐ Other ☐ Permanent Supportive Housing ☐ Public Housing ☐ SNAP ☐ WIC

Countable Income Information

Customer Name:	Total Amount Received	Period Received (30, 90 or 365 days)
	$	
	$	
	$	
	$	
	$	
	$	
	$	

Income Category:		Frequency:	Total Amount:
☐ Fixed	☐ SSI ☐ SSDI ☐ SSA ☐ Pension ☐ Window/Widower's benefit ☐ Adoption Assistance ☐ Alimony ☐ Black Lung pension	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Earned	☐ Wages ☐ Self-employment ☐ Active Military Pay ☐ Ohio Electronic Child care	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Supplemental	☐ Unemployment ☐ Utility Assistance ☐ Workers' Compensation ☐ Ohio Works First (TANF, ADC)	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ Other	☐ Cash withdraws from: IRA, Annuities, Other investments ☐ Lump sum payout from: SSI, SSDI, Estate & Trust settlements, Divorce settlements, insurance payout, lotter winnings ☐ Interest Income	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
☐ None			$ _____
		Total:	$ _____

Deductions:

Deductible Income:	Frequency:	Total Amount:
☐ Health Insurance Premiums ☐ Health Care Spending Accounts ☐ Medicaid Spend Down (deductibles) ☐ Medicare Part D (RX premium) ☐ Child Support paid-out ☐ Attorney fees for estate or trust settlements	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____
	Total Household Income (Countable Income – Deductions)	$ _____
	Federal Poverty Level:	_____ %

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____

Approved by: _____ Date: _____

Excluded Income:	Frequency:	Total Amount:
☐ Agency Orange Pension ☐ Veterans affairs, service related disability ☐ Handicapped income (i.e. work programs for the blind or disabled) ☐ Title V wages (i.e. senior employment programs) ☐ Volunteers in Service to America Stipend (VISTA) ☐ Work allowances (work requirement to receive OWF assistance) ☐ Income earned by dependent minors ☐ Tax refunds/rebates ☐ Education assistance (grants stipends for tuition/books) ☐ Stipends for foster care ☐ Military allowances for subsistence ☐ Ohio waiver program (Medicaid benefit for caregiver) ☐ Prevention retention and contingency (i.e. emergency services, rental asst.) ☐ transportation allowances (WIOA) ☐ Proceeds from reverse mortgage ☐ FEMA, cash payments ☐ Title III Disaster relief emergency assistance	☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	$ _____

Expense Type:	Total Monthly Expense amount:
Food	$ _____
Shelter	$ _____
Child Care	$ _____
Transportation	$ _____
Utilities	$ _____
	$ _____
Total:	$ _____

Ohio Department of Education - Office for Child Nutrition

CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required Form for use by Child Care Centers and Head Start Programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion

- All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center.
- List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care.
- If schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- If the child comes before and after school, list the hours in care for both the morning and afternoon.
- CACFP Federal regulations 226.15(e) (2) require that an enrollment form be **completed annually** and signed by the child's parent or guardian.

CENTER NAME

CHILD'S NAME (please print) | **AGE** | **BIRTHDATE** month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE

Check (✓) Days Child Normally in Care		List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
		Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											
Saturday											
Sunday											

☐ Yes, **The schedule listed above may frequently vary due to changes in parents/guardians schedule**

SIGNATURE OF PARENT/GUARDIAN | **DATE** | **DAY PHONE NUMBER**

MAILING ADDRESS: STREET /APT. | **CITY** | **ZIP CODE**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

(rev. 12/3/2015)

HIGHLAND COUNTY HEAD START

HILLSBORO • GREENFIELD • BELFAST

Dental Examination Form

CHILD'S NAME: _____ **SEX:** ____ **BIRTH DATE:** ___/___/___ **AGE:** _____

PARENT(S) NAME: _____ **PHONE NUMBER:** _____

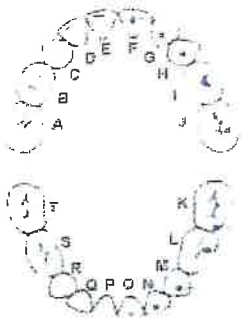
INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

1) Diagnostic and Preventive Procedures Performed:
- ❑ Clinical Examinations
- ❑ Prophylaxis
- ❑ X-Rays
- ❑ Fluoride application
- ❑ Other _____

EXAMINATION AND TREATMENT RECORD:
INDICATE TEETH NEEDING TREATMENT (below on chart)

DATE OF EXAM: _____

Tooth # or letter	Description of Dental Services Required



Upper Teeth	Shed
Central Incisor	6-7 yrs.
Lateral Incisor	7-8 yrs.
Canine (Cuspid)	10-12 yrs.
First Molar	9-11 yrs
Second Molar	10-12 yrs.

Lower Teeth	Shed
Second Molar	10-12 yrs.
First Molar	9-11 yrs
Canine (Cuspid)	9-12 yrs
Lateral incisor	7-8 yrs.
Central incisor	6-7 yrs.

2) Current Status: Cavities: _____ (How Many) Recurrent decay around old fillings: _____ (How Many)

Gums and supporting tissues: ❑ Normal & Healthy ❑ Slight inflammation (gingivitis) ❑ Moderate inflammation

❑ Advanced disease (periodontitis) Other: _____

3) Recommendation:

❑ No further treatment recommended at this time. Return in _____ months for a routine cleaning and examination.

❑ Additional dental treatment is required. Please complete the Treatment/Follow-up Plan identified below:

TREATMENT/ FOLLOW-UP PLAN

DENTAL TREATMENTS: Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

_____
DATE ALL TREATMENT WAS COMPLETED

I Certify that I, the Dental Care Provider has completed the service(s) listed in section 1, 2, & 3 including the Follow-Up Plan(If needed).

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____ _____
Address, City, State & Zip Code Phone Number Fax Number

THIS FORM IS TO BE COMPLETED BY A DENTAL CARE PROVIDER.

Please fax and/or return this form to: H.C.C.A.O Head Start • PO box 838 • 1487 N. High St., Hillsboro, Ohio, 45133
(937) 393-3458 • Fax (937) 393-7175

Revised 12/2008