FIVE SANDOVAL INDIAN PUEBLOS, INC. HEAD START PROGRAM

HEALTH APPRAISAL PER EPSDT

Name of Clinic: **Address:** **Phone Number:**	**Child's Name:** **Date of Birth:**

The remainder of this form is to be completed and signed by a licensed Health Care Professional (Doctor).

Does child have visible cavities?	☐ Yes (explain):	☐ No
Do you have any nutritional concerns? (i.e. history of iron deficiency anemia, recent weight gain or loss, high weight for height)	☐ Yes (explain):	☐ No
Are there food allergies/sensitivities that need to be accommodated in the classroom?	☐ Yes (explain):	☐ No
Do you have any concerns about the child's communication, cognitive/ behavioral skills?	☐ Yes (explain):	☐ No
Are there any conditions that need accommodations in the classroom? (I.e. asthma, allergies, delays in language, birth defects etc.)	☐ Yes (explain):	☐ No
Are there any medications that should be dispensed in the classroom?	☐ Yes (explain):	☐ No
Are there any conditions that require follow-up treatment?	☐ Yes (explain):	☐ No
Is the child up to date on a schedule of age-appropriate, preventative and primary health care?	☐ Yes	☐ No (explain):

REQUIRED SCREENING

Results of Lead Screening _____ **Date of Screening:** _____

Results of Hemoglobin Screening _____ **Date of Screening:** _____

Next Well Child Exam/Follow-up Appointment: _____

Follow-up Indicated ☐ Yes ☐ No Follow-up in Progress ☐ Yes ☐ No

Follow-up/Treatment is: ☐COMPLETE ☐ NOT COMPLETE

Additional Comments:

Name of HealthCare Provider:	**Phone Number:**

Signature of Provider: _____ **Date:** _____

PLEASE RETURN EXAM RECORD TO: FSIP, INC. HEAD START
4321-B FULCRUM WAY NE, RIO RANCHO, NM 87144
ATTENTION TO: YVETTE AGUILAR OR LAVONNE CATE
PHONE 505-867-3351/FAX 505-867-3514