STEPS is currently accepting applications for enrollment into STEPS Head Start, Early Head Start, Mixed Delivery, and Childcare for the 2024-2025 program year. STEPS offers high quality early education and intervention programs and enrollment is contingent on meeting program eligibility guidelines.

The following programs are offered at no monetary cost to families – Head Start serving children ages 3 to 4 years of age, Early Head Start serving children 6 weeks-36 months, and Mixed Delivery currently available for Toddlers & Two year olds in Prince Edward County.

If you are interested, attach copies of the following information listed below with your completed application:

- Proof of income (1040 or 1040A) **2023 Tax Return or W-2 Form (s), unemployment documentation or other financial assistance**
- If you received assistance from Social Services (i.e. TANF, SSI, SNAP, Kinship, or other sources) Please attach a statement from your case worker listing the amount you receive monthly.
- Proof of residency (i.e. power bill, lease).
- If you receive child support, please include a copy of the court order with the dollar amount awarded. We will need a copy of all custody orders.
- Proof of child's birth (i.e. birth certificate, proof of birth letter).
- Child's Medical Insurance or Medicaid card number.

Incomplete application or documentation will not be accepted and will result in your application not being processed.

Once your application is approved and your child is accepted into the program, you will need to provide the following attached forms completely filled out and signed by the appropriate health care provider:

- School Health Entrance Form (physical must have been completed within the past 12 months)
- Child Dental Exam Record (exam completed within the past 6 months)

If your child is accepted and you do not provide the required medical and dental forms they will not be able to attend the program.

Limited private pay and subsidized childcare spots will be available in Prince Edward County in the Fall of 2024.

If you have any questions, or need assistance completing the application please contact:

Taneha Terry
434-315-5909 x 24
tterry@steps-inc.org

STEPS Head Start & Childcare
Moving Lives Forward
www.stepsheadstart.com

STEPS Head Start & Childcare
Moving Lives Forward
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Application for Enrollment

Child Care Site Applying for (County Name):_____

Which program are you looking for: ☐ Private Pay Childcare ☐ Susidized Childcare ☐ Mixed Delivery (Infant/Toddler)
☐ Head Start (Early Head Start) ☐ Whichever Program I qualify for

What best describes your child's age group: ☐ Head Start/Preschool (3-5 year old) ☐ Toddler Care (16 -36 months)
☐ Infants (Birth – 15 months old)

Which option works best for you: ☐ 10-month program (follows school division schedule) ☐ 12-month year round program

Applicant & Family Member Information

Applicant (Child) – All boxes must be checked off and filled.

First	Middle	Last	Suffix	Nickname	Birthdate	Gender

Diagnosed/ Suspected Disability or Developmental Delay?	Disability Evaluation Date:	Who Conducted the Evaluation?
☐ Yes, Describe: ☐ No		

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Child's Doctor
			☐ Not Eligible ☐ On Medicaid ☐ Potentially		

Dental Coverage	Dental Coverage #	Doctor/Medical Home	Dentist/Dental Home

The following questions are intended to help determine the eligibility of the child for STEPS programs. This will allow us to determine the best fit for you and your child.

Any chronic (long term) Health Problems of Applicant ☐ No ☐ Yes If yes, what _____
Child lives with ☐ Mother ☐ Father ☐ Other (Specify) _____
Are there abuse issues in the home ☐ No ☐ Yes (check all that apply ☐ child or spousal ☐ drug or alcohol)
Does the child have an incarcerated parent ☐ No ☐ Yes (check all that apply ☐ one parent ☐ both parents)
Has the child previously been enrolled in Head Start or Early Head Start ☐ No ☐ Yes
The child has a sibling already in Head Start/Early Head Start ☐ No ☐ Yes Name of Sibling_____
Has there been a death in household within the last 6 months ☐ No ☐ Yes
Did you receive a referral to STEPS by a professional or agency ☐ No ☐ Yes (MD, LEA, WIC, Shelter, DSS, etc.) If yes, who referred you? _____

TRANSPORTATION: Transportation services are based on family needs, circumstances, and availability of services. Transportation services are not guaranteed with enrollment into the program.

****Transportation is NOT provided for infants, toddlers, or private pay students****

1. Distance from center: ☐ 0 - .5 miles ☐ 3/4 - 1.5 miles ☐ 1.5 - 3 miles ☐ 3.5 - 5 miles ☐ More than 5.5 miles
2. Is there someone available to bring your child to school and pick them up from school? ☐ No ☐ Yes

HOUSING: Please answer the following questions regarding the applicants' current living situation. The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435.

☐ Moving from place to place/couch surfing. We have places to stay with friends and family, but we move around a lot. ☐ In a motel/hotel or similar ☐ A car, park, campsite, or similar location ☐ Transitional Housing ☐ In a residence with inadequate facilities (no water, heat, electricity, etc.) ☐ Other: Please provide details	☐ In an emergency or transitional shelter ☐ In someone else's house or apartment with another family. Examples: the family lives at a parent, aunt, uncle, or friend's house. ☐ Child lives with family or friends who are not the custodial parent or guardian. ☐ Child often sleeps or stays in public places or places that are not ordinarily used as a regular sleeping location. ☐ We own our home. ☐ We rent a home.
Parent/Guardian: 1. Do you have a key to the home you live in with the child? ☐No ☐Yes	2. Do you have access to a kitchen where you stay? Can you cook in the house and store food there? ☐No ☐Yes

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

Primary Adult- Should be the custodial parent/guardian. All boxes must be checked off and/or filled.

First	Middle	Last	Suffix	Nickname	Birthdate	Gender

Diagnosed/ Suspected Disability or Developmental Delay?	Disability Evaluation Date:	Who Conducted the Evaluation?
☐ Yes, Describe: ☐ No		

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ < Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ GED ☐ HS Grad	☐ College Certificate - Training ☐ Associate ☐ Bachelor ☐ Masters ☐ Doctoral	☐ Full Time ☐ Part Time ☐ Seasonal ☐Unemployed	☐ Full Time & Train ☐ Part Time & Train ☐ Training or School ☐ Retired or Disabled	☐ Biological Adopted Stepchild ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent ☐ No ☐ Yes - If teen parent, subsidized? ☐ Yes ☐ No

Email Address: _____ **Address:** _____

Secondary Adult- Should be the custodial parent/guardian. All boxes must be checked off and/or filled.

First	Middle	Last	Suffix	Nickname	Birthdate	Gender

Diagnosed/ Suspected Disability or Developmental Delay?	Disability Evaluation Date:	Who Conducted the Evaluation?
☐ Yes, Describe: ☐ No		

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ < Grade 9 ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ GED ☐ HS Grad	☐ College Certificate - Training ☐ Associate ☐ Bachelor ☐ Masters ☐ Doctoral	☐ Full Time ☐ Part Time ☐ Seasonal ☐Unemployed	☐ Full Time & Train ☐ Part Time & Train ☐ Training or School ☐ Retired or Disabled	☐ Biological Adopted Stepchild ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent ☐ No ☐ Yes - If teen parent, subsidized? ☐ Yes ☐ No

Email Address: ____ **Address:** ____

Additional Child (Non-Applicant) *-List all siblings of the applicant, including other children applying

First	Middle	Last	Suffix	Nickname	Birthday	Gender	Has Disability
						☐ Male ☐	☐ Yes ☐ No

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Additional Child (Non-Applicant) *-List all siblings of the applicant, including other children applying

First	Middle	Last	Suffix	Nickname	Birthday	Gender	Has Disability
						☐ Male ☐	☐ Yes ☐ No

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Additional Child (Non-Applicant) *-List all siblings of the applicant, including other children applying

First	Middle	Last	Suffix	Nickname	Birthday	Gender	Has Disability
						☐ Male ☐	☐ Yes ☐ No

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Additional Child (Non-Applicant) *-List all siblings of the applicant, including other children applying							
First	Middle	Last	Suffix	Nickname	Birthday	Gender	Has Disability
						☐ Male ☐	☐ Yes ☐ No

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ Black ☐ White ☐ Other:	☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Multi-Racial	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Family Information, Income & Contacts

Family Information

Family Living Address

Date You Started Living Here?	Living Street Address	ZIP	City	State	County

Family Mailing Address

Same as living?	Starte Using Date	Mailing Address	Zip	City	State

Phone Number(s)	Type (*check one*)	Note (Mom, Dad, ext., best time to call)	Opt. in for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Active Duty Military	What is the primary language of the family spoken in the home?	What language does the applicant (child) speak in the home?	Preferred Language of Written Material
☐ One ☐ Two	☐ Yes ☐ No			

Family Income

TANF Status	SSI	Homeless Family	Receiving SNAP	WIC	Referred by Child Welfare Agency
☐ Yes ☐ No ☐ Formerly on TANF Not now	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Emergency Contacts- A minimum of two (2) are required by Licensing.
Please do not list the primary or secondary adult in the home, they are always the 1st contact.

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐Home ☐ Work		☐ Cell ☐Home ☐ Work		☐ Cell ☐ Home ☐ Work

Contact 2	Name	Relationship	Emergency Contact	Release To
			☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐Home ☐ Work		☐ Cell ☐Home ☐ Work		☐ Cell ☐ Home ☐ Work

Contact 3	Name	Relationship	Emergency Contact	Release To
			☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐Home ☐ Work		☐ Cell ☐Home ☐ Work		☐ Cell ☐ Home ☐ Work

STEPS makes every effort to find a placement for each child. We offer a variety of diverse programs, and we work closely with community partners to coordinate enrollment.

For applicants seeking Head Start or Mixed Delivery preschool services do you authorize STEPS Head Start to share your information with the local VPI Coordinator in your county of residency to assist with community wide preschool recruitment and placement. ☐ No ☐ Yes

Is STEPS your first choice for a preschool program ☐ Yes ☐ No, if No please provide details:

_____

_____

_____.

STEPS childcare programs are state licensed through the Virginia Department of Education and adhere to the requirements of the Unified Virginia Quality Birth to Five System. All programs use a research based curriculum and assessment tool to prepare children and families for school readiness.

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature _____ Date _____

Office Use Only:

Received By: _____ Date Received: _____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/____/_____ Sex: _____ State or Country of Birth:_____Main Language Spoken: _____

Student's Address_____ City_____ State_____ Zip Code_____

Name of Parent or Legal Guardian 1:_____Phone:_____-_____-_____Work or Cell: _____ - _____-_____

Name of Parent or Legal Guardian 2:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Emergency Contact:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS☐ Private/Commercial/ Employer Sponsored☐_____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (☐ Feeding tube , ☐ Trach , ☐Oxygen support, ☐ Hearing aids, ☐ Dental appliance, ☐ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I_____(do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian:_____Date:_____/_____/_____

Signature of Interpreter: _____Date_____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** ☐ **Hispanic** ☐ **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis **B** Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis **A** Vaccine	1	2			
Meningococcal **ACWY** Vaccine	1	2			
Meningococcal **B** Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):** 12 /___/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[_____]; RV:[____]; Measles :[_____];

Mumps:[____]; Rubella :[____]; VAR:[_____]; Men ACWY:[____]; Men B:[____]; Hep A:[_____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |_____|_____|_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth:_____/_____/_____Sex: M F

Health Assessment

Date of Assessment: ____/____/_____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date: TST Reading mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

❑ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

Stereopsis ☐ Pass ☐ Fail				☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ Well child; no conditions identified of concern to school program activities

Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____

Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

____I**ndividualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

____**Restricted Activity Specify:** :_____

____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

____**Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

____**Special Diet Specify:** _____

____**Special Needs Specify:**_____

Other Comments:_____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:_____ **Signature:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:** _____-_____-_____ **Email:**_____

STEPS Head Start
Moving Lives Forward

Dental Examination Report

Child's Information	
Child's Name:	**DOB:**
County of Residency:	
Dentist's Information	
Dentist's Name:	**Phone Number:**
Clinic Name: (If different)	**Fax Number:**
Clinic Address:	
City/ State/ Zip Code:	
Visit Summary	
Date of Screening/Appointment:	

(Completed by Dentist or designee)

Please check services provided at today's appointment:

☐ **Exam** ☐ **Fluoride** ☐ **Prophylaxis** ☐ **Treatment**

Any additional services provided: _____

Follow- Up Plan

☐ **Check here if all dental work completed.**

☐ **Check here if additional work is required.**

What follow-up is needed? _____

Next dental appointment is scheduled on _____ @ _____

Dentist's Signature: **Date:**