EAST BATON ROUGE HEAD START

Health Requirements and Instructions for Parents and Providers

Information in this document is to help parents understand the importance and timelines for health requirements for children enrolled in East Baton Rouge Parish Head Start Program. The Early and Periodic Screening, Diagnostic and Treatment (hereinafter "EPSDT") benefit provides comprehensive and preventive health care services for children who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. EPSDT is a key part of Medicaid for children and adolescents. EPSDT emphasizes preventive and comprehensive care.

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified
- **Treatment:** Control, correct or reduce health problems found.

Each child primary care provider has to complete the attached Physical Examination Form and the child's dentist has to complete the attached Dental Form. Both forms need to be completed in its entirety along with the providers' signature and the date of service.

1. **Within 30 days of enrollment-** Determining a source of health care consulting with parents to determine whether each child has ongoing sources of continuous, accessible health care provided by a health care professional that maintains the child's ongoing health record and is not primarily a source of emergency or urgent care and health insurance coverage.

2. **Within 45 calendar days of enrollment-** we must either obtain from the parent copies of evidence-based vision and hearing screenings or through community resources acquire these screenings.

3. **Within 90 calendar days of enrollment –** we must ensure that all children health status is up-to-date. Verifying all EPSDT screenings are current including Oral/Dental care.

4. **On-going care-** will be through Head Start staff working with parents to help them in keeping their child up to date through reminders such as word of mouth, emails and letters.

5. **Lead Screen Results-** It is essential that children enrolled in the Medicaid receive appropriate blood lead screening tests. All children enrolled in Medicaid are required to receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted. The results of the test are required by Head Start. Any child receiving a result of 5, parent will be notified by staff to monitor the lead intake through our nutrition staff and those with a result of 10 or higher must be monitored and reported to the Louisiana Department of Health.

RETURN COMPLETED MEDICAL/DENTAL FORMS TO YOUR CHILD'S CENTER

East Baton Rouge Parish Head Start Program

ATTENTION PROVIDER:

Head Start requires a COMPLETE EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE 3 Yrs ☐ 4 Yrs ☐ 5 Yrs ☐

CHILD'S NAME	DATE OF BIRTH	CENTER

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE	
CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM
ADDRESS		

EXAMINATION RESULTS

HEIGHT	WEIGHT	BLOOD PRESSURE
ft inches	lbs oz	

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin			Mouth/ Teeth/ Oral Health Assessment			Genitalia		
						Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Developmental		
Nose			Abdomen			Behavioral		

Vision Acuity		Right	Left	Both
Date		/	/	/
Test Type	Evidence Based Only			

Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date		1000 Hz	dB	dB
		2000 Hz	dB	dB
Test Type	Evidence Based Only	3000 Hz	dB	dB
		4000 Hz	dB	dB

Hemoglobin

☐ **No Risk, screening not required** (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT
		☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	
		☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS			DATE READ
	mm	☐ Non-Significant	☐ Significant	

DATE OF CHEST X-RAY			RX DATE
	☐ Normal	☐ Abnormal	

Lead Risk Assessment

☐ At Risk ☐ No Risk

Immunizations

GIVEN TODAY

☐ Yes ☐ No List:______________________________

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings	Treatment/Restrictions/Recommendations for School

Does the child have asthma?

☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL

☐ Yes ☐ No **(If yes, Medication Administration form needed)**

Child is physically and emotionally able to participate in program

☐ Yes ☐ No **(If no, please explain in space above)**

TYPE OF MEDICATION AND PURPOSE

Date Physical was completed:____________________________ **Physician's Signature:**____________________________

Head Start Oral Health Form—Children

Patient Information

Child's name ____ Date of birth

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No

X-rays: ☐ Yes ☐ No

Risk Assessment: ☐ Yes ☐ No

Cleaning: ☐ Yes ☐ No

Fluoride varnish: ☐ Yes ☐ No

Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

____

(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No

Crowns: ☐ Yes ☐ No

Extractions: ☐ Yes ☐ No

Emergency care: ☐ Yes ☐ No

Other: ________________________________

(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No

Next recall date:________/________(month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed:______Next appointment: Date:_____________Time: ___________

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* ________________ Phone number ________________ Fax number

Practice name ________________ Address

Provider signature ________________ Date of service