Fort Peck Tribes Head Start Program Health Screening Form
2023 – 2024

Child's Name ------	First:	Middle:	Last:
D.O.B: / /	Weight:	Height:	BMI:
Gender: Female or Male	What Health Coverage do you have? (Circle one) IHS PRIVATE MEDICAID OTHER		
Toilet Trained: Yes or No	If No, are working on Toilet Training?		

TO BE COMPLETED BY HEALTH CARE PROVIDER

EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL
Blood Pressure			Oral Health Assessment			Genitalia		
Skin						Neurologic		
Neck			Throat			Extremities		
Head			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Bones		
Nose			Abdomen			Muscle Coordination		

Physician Signature:	**Physical Date:**	Physician Location (Circle) I.H.S H.P.D.P Private Other

DENTAL EXAM	NORMAL	ABNORMAL	DIAGNOSIS/ABNORMAL FINDINGS COMMENT…..
Screening			Dental Referral Date:
X-Ray			
	N#	Referral	
Cavities			Location:
Fillings			
Dentist Signature & Location:			

VISION EXAM

Glasses Prescribed Yes or No	Right: /	Left: /	Results Pass / Fail
Optometrist Signature & Location:			

HEARING EXAM

Results		Right	Left
Pass / Fail	Pure Tone Screening		
	Tympanograms		
	NO WHISPER TEST		
Audiologist Signature & Location:			

HEMOGLOBIN/HEMATOCRIT

HGB(g/dl):	Risk Anemia: Yes or No
Results: ________________ Date:	Follow-up or Concerns:

LEAD

Lead Level (mcg/dl):	Risk of High Lead Levels: Yes or No
Date:	Follow-up or Concerns:

Nutrition

How many times each week does your child eat food from the Following food groups?

Milk Cheese Etc.	Meat Fish Yogurt Eggs	Veggies Carrots Peas Corn Ect	Bread Rice Pasta Cereals	Oil Butter Cookies Cakes Candy
1. 2. 3. 4. 5. 6+ Days	1. 2. 3 4. 5. 6- Days	1. 2. 3. 4. 5. 6+ Days	1. 2. 3. 4. 5. 6+ Days	1. 2. 3. 4. 5. 6+ Days

Allergies

Type of Allergy:

Question	Answer
1. Does your child take Any Vitamins?	1. Yes or No
2. Is your child on a Special Diet?	2. Yes or No
3. Is there any Food your child should not eat for Medical, Religious, or Personal Reasons?	3. Yes or No If Yes, please provide Documentation.

Do you have any concerns about your child's eating? ____________
____

Does your child have Trouble Chewing or Swallowing for any Medical reasons? Yes or No, If Yes please explain: ____________________
____

Please continue on the back portion of this document Thank You

IMMUNIZATIONS

Please check below if they are updated or needing immunizations

REQUIRED VACCINE	Up-To-Date	Needing Immunizations
Haemophilus Influenza Type B (Hib)		
Diphtheria, Tetanus, & Pertussis (DTAP)		
Polio (IPV or OPV)		
Measles, Mumps, & Rubella (MMR)		
Varicella "Chickenpox" (Var)		

** ***Please attach a copy of your child's immunization record*** **

Fort Peck Head Start
Parent/Guardian Permission to Reveal or Obtain Confidential Information

I, ___________________________________, give the Fort Peck Head Start Program consent to obtain from or give to the following agencies and/ or person pertinent social, medical or other information about ____________________________(Child's Name) for whom I am legally responsible for. In granting such permission, I understand that such information will remain confidential and will be used for the benefit of the above named child. This consent is valid until child completes Head Start.

	Name of Agency/Public School Districts	
Verne E. Gibbs I.H.S.	**Frazer Public Schools**	**HPDP**
Chief RedStone I.H.S.	**Wolf Point Public Schools**	**Little Holy One John Hopkins University Project**
Riverside Family Clinic	**Poplar Public Schools**	**Rimrock Pediatric Dentistry**
Roosevelt Medical Center	**Brockton Public Schools**	**Youth Dynamics**
Listerud Rural Health Clinic	**Culbertson Public Schools**	**BIA Social Services**
Roosevelt County Health	**Hi-Line Homes**	**State of Montana Child Protective Services (CFS)**
N. E. M. H. S. Wolf Point/Poplar	**Roosevelt County OPA**	**477 Program**

I release the Fort Peck Head Start from any legal liability for disclosing or acquiring information which I have permitted by signing this form. I also release the above agencies from any liability for giving information to the Fort Peck Head Start until completion of the program.

_______Yes, I do / _______No, I do not give permission for the Fort Peck Tribes Head Start Program to work with the necessary agency to better accommodate my family's experience.

Signature of Parent/Legal Guardian: _____________________________ Date: _________________