Community Colleges of Spokane

Spokane Head Start/ECEAP/EHS
WELL-CHILD EXAMINATION

Date_____

Dear Health Care Professional:

According to **(FEDERAL PERFORMANCE STANDARD: 45 CFR 1304.20(a) (1) (ii) & (A)) and State ECEAP Performance Standard D-9:**

Head Start/Early Head Start Federal and State ECEAP programs are required to obtain from a health care professional a determination as to whether a child is up-to-date on a schedule of age appropriate preventive and primary health care. The schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate. This exam must include immunization recommendations issued by the Centers for Disease Control and Prevention.

Head Start/ECEAP/EHS follows the law for immunizations required for enrollment in Child Care (WAC 388-295-7020).

The Washington EPSDT Periodicity Schedule listed below is the resource we use to assist families in keeping their children up-to-date with well-child care.

To comply with the performance standard requirements we need the health-care provider to provide information requested on the back of this letter, including: immunizations administered and a complete copy of the Well-Child Exam, **parent authorization is included with this request and valid for the current school year as indicated on the back of this form.**

Thank you for taking the time to complete the information and returning the form to the program in a timely manner. Program guidelines require that we keep the information in a confidential child file. If you have any questions please do not hesitate to call.

Sincerely,

Jordon Groce
HS/EHS Health Specialist
533-4833/fax 533-4850

Kimberly Lopes BS Physical & Health Education, MS Curriculum & Instruction
ECEAP Health, Safety and Nutrition Specialist
533-4868/fax 533-4850

Washington EPSDT Periodicity Schedule (as of July 1, 2006)

Age[5]	Prenatal[1]	Newborn[2]	2-4d[3]	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 y	4 y	5 y
History															
Initial/Interval	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Measurements															
Height and weight		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head Circumference		x	x	x	x	x	x	x	x	x	x	x			
Blood Pressure													x	x	x
Sensory Screening															
Vision		S	S	S	S	S	S	S	S	S	S	S	O[6]	O	O
Hearing		O	S	S	S	S	S	S	S	S	S	S	S	O	O
Developmental/ Behavioral Assess.[8]		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Physical Examination[9]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Procedures–General[10]															
Hereditary/Metabolic Screening[11]		◄	x	►											
Immunization[12]		x	x	x	x	x	x	x	x	x	x	x	x	x	x
Hematocrit or Hemoglobin[13]								x	►	R	—	—	—	—	►
Urinalysis															x
Procedures–Patients at Risk															
Tuberculin Test[15]										R	R	R	R	R	R
Cholesterol Screening[16]												R	R	R	R
Anticipatory Guidance[17]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Injury Prevention[18]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Violence Prevention[19]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Sleep Positioning Counseling[20]	x	x	x	x	x	x	x								
Nutrition Counseling[21]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dental Referral[22]									◄	—	—	—	x		

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

KEY:

x = to be performed
O = objective, by a standard testing method
S = subjective, by history
R = to be performed for patients at risk
◄—x—► = subjective, by history

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PARENT AUTHORIZATION AND WELL-CHILD EXAMINATION RECORD

PARENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Head Start/ECEAP/EHS and my child's primary care provider,

(provider name)_____
to receive and disclose information regarding current well-child exams, immunizations, lab work, referral, follow-up and/or treatment recommendations regarding:

Child's name_____ Birth date_____

Parent/legal guardian (please print)_____

Parent's/guardian's signature_____ Date_____

AUTHORIZATION IS VALID FOR PROGRAM YEAR, BEGINNING ____/____/____ and ending ____/____/____.
PARENT/GUARDIAN MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

WELL-CHILD EXAMINATION INFORMATION

1. Is child up-to-date for **WA State EPSDT** well child care? ❑ Yes ❑ No

   CURRENT EXAM DATE_____ **NEXT EXAM DUE**_____

2. **Immunizations** given (or attach copy of immunization record)_____

3. Complete copy of current EPSDT Well-Child Exam included: ❑ Yes ❑ No

Treatment, Referral, Follow-up needed? ❑ Yes ❑ No If **Yes,** please explain:

The program would be glad to assist and support the treatment plan, referral or follow-up needed. Please explain:

RETURN THIS FORM TO:

_____
Signature of provider (required)

_____
Name of health care provider (please print)

_____
Provider's phone