Thrivalaska Head Start Birth to Five
EHS Health History Packet

Child's Name: _____ Date of Birth: _____ Gender: M F

BIRTH HISTORY

Was your child born early? ☐ Yes ☐ No If yes, how early? _____ Birth Weight: _____ lbs. _____ oz.

Did your child receive a newborn hearing screening while in the hospital? ☐ Yes ☐ No ☐ Unsure

Did your child receive any follow up services? ☐ Yes ☐ No

GENERAL HEALTH

Does your child have frequent:	N//A	How often	Most recent occurrence	Was it treated?	If yes, by what Dr. or clinic?
Seizures *If needed, complete classroom care plan	☐				
Asthma/Respiratory Problems *If yes, complete Asthma Information Form	☐				
Allergies *If yes complete an Allergy Form	☐				
Eczema/skin problems	☐				
Vision problems	☐				
Hearing problems	☐				
Anemia (low iron)	☐				
Chronic condition (list)	☐				
Other health concerns	☐				

Does your child wear glasses? ☐ Yes ☐ No

Does your child wear hearing aids? ☐ Yes ☐ No

Does your child have tubes in their ears? ☐ Yes ☐ No

Has your child been hospitalized? Please explain. ☐ Yes ☐ No

_____

Is your child currently taking any medication? ☐ Yes ☐ No
If yes, reason for medication, name of medication, time taken and amount

_____

Do you have social/ emotional/ behavioral concerns for your child? ☐ Yes ☐ No

_____

Thrivalaska Head Start Birth to Five

MEDICAL/DENTAL COVERAGE

Does your child have medical insurance? ☐ Yes ☐ No

Does it cover DENTAL EXAMS? ☐ Yes ☐ No

VISION EXAMS /glasses? ☐ Yes ☐ No

If yes, what type?

☐ Medicaid ☐ Denali Kids Care

☐ Private Insurance (name of insurance company) _____

Does your child have a Medical Home? ☐ Yes ☐ No

Physicians/Clinic Name: _____

Date of Last Well-Child Exam: _____ Date of Next Exam (if known):_____

Does your child have a Dental Home? ☐ Yes ☐ No

Dentist/Clinic Name: _____

Date of Last Dental Exam: _____ Date of Next Exam (if known): _____

Is your child taking a fluoride supplement ☐ Yes ☐ No

Has your child received fluoride treatment or varnish during doctor visit or dental visit ☐ Yes ☐ No

Has your child had an eye exam? ☐ Yes ☐ No

Ophthalmologist, Optometrist or vision center Name: _____

Do you need assistance in finding a medical/dental provider? ☐ Yes ☐ No

Do you need information about health insurance? ☐ Yes ☐ No

Insurance

Thrivalaska carries liability insurance. If your child is injured at Thrivalaska and requires a visit to the doctor, Thrivalaska will act as the primary insurance carrier if you have no other medical insurance. Thrivalaska will act as the secondary insurance carrier if you have other medical insurance. Each program has insurance forms available.

Thrivalaska Head Start Birth to Five
1949 Gillam Way, Fairbanks, Alaska 99701
Phone: (907) 452-4267 / Fax: (907) 452-4203

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Child's Printed Name: _____ Birth date: _____

As the parent/guardian of _____, I give permission for Thrivalaska Head Start Birth to Five staff to obtain the following confidential health records from our doctors, dentist and clinic listed above.

- Most recent physical exam
- Diagnosis of illness that required my child to visit the doctor
- Most recent dental exam with schedule of treatment if needed
- Laboratory reports and results (blood lead, hemoglobin)
- Most recent immunization record
- Eye exam results with schedule of treatment if needed
- Care Plan (medication, allergy)

I understand that I have the right to receive a copy of this confidential information. I also understand that the information in these records will be treated in a confidential manner and will not be transmitted to a third party without my written consent.

Expiration Date: This authorization shall expire 1 year from the date of signature, unless revoked prior to the date _____.

Parent Signature _____ Date_____

Staff Signature _____ Date_____

FOUNDATION HEALTH PARTNERS
TANANA VALLEY CLINIC

TVC Health Information
1001 Noble Street
Fairbanks, AK 99701
P: (907) 458-2647 F: (907) 459-3566
TVCrecords@foundationhealth.org

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth** _____
Maiden Name/Other Names Known By: _____ **Phone #:** _____

I hereby authorize Tanana Valley Clinic to:
☐ Release Information To: ☐ Obtain Information From:
Person/Facility Name: _____
Address: _____
Phone #: _____ Fax#: _____

Dates of Treatment Requested:

Information being requested *(Check all that apply):*
☐ Entire Record (Includes all items listed) ☐ Pathology Reports ☐ Radiology Reports
☐ Office Visits/Progress Notes ☐ Laboratory Reports ☐ EKG Reports
☐ Shot records ☐ Others (please specify): _____

Delivery of Records: ☐ Mail ☐ Pick Up **and/or** ☐ Email ☐ NextMD ☐ CD ☐ Paper

Email Address for record delivery

(Complete ONLY if requesting records via e-mail)
☐ **I do NOT want my electronic record Encrypted** ☐ **I do want my electronic record Encrypted**
Unencrypted data sent by e-mail can be intercepted by unauthorized parties

Purpose of Information: ☐ Self ☐ Continued Treatment ☐ Others (please specify): _____

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/ Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes the release of any such information.

I may refuse to sign this authorization form. I understand that Foundation Health Partners will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Foundation Health Partner's Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Foundation Health Partners, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized here in.

Signature of Patient/Legal Representative: _____ Date: _____
Relationship to Patient: _____ ID/License #: _____

FOR OFFICE USE ONLY

TVC MR #: _____ Request Taken By: _____	Date Completed: _____
Date of Request: _____ Date Needed: _____	Request Completed By: _____
Pick up Fax Mail NextMD E-mail	Pick up Fax Mail NextMD Email

Thrivalaska Head Start Birth to Five

Parental Consent Form – Medical

Child's Name: _____

All health screenings will be completed by qualified specialist or Thrivalaska Head Start Staff. Health screenings will be completed on an age appropriate basis. I give permission for the following:

Vision screening	☐ Yes	☐ No
Hearing screening	☐ Yes	☐ No
Height/ Weight	☐ Yes	☐ No
Dental Screening if provided by the program	☐ Yes	☐ No
Nutritional Assessment by program dietitian	☐ Yes	☐ No
Blood Lead Screening	☐ Yes	☐ No

Screenings marked NO- must complete a Refusal to Authorize Form. Completion of these screenings will be the responsibility of the parent. We are mandated by regulation to carefully document instances where parents or legal guardians have refused to authorize health care services for their child. Please help us document this instance by signing below.

Thrivalaska will provide generic or store brands of the following items. Brands may change due to availability. Ask your child's teacher for the current brand being used. Treatments marked NO- parents will need to supply item and complete a Medication Administration Form.

All ointments, lotions or creams listed below will be provided by Thrivalaska Head Start. I give permission for the application of:

A&D ointment for chapped/dry skin	☐ Yes	☐ No
Insect Repellant	☐ Yes	☐ No
Sunscreen	☐ Yes	☐ No
Baby Lotion	☐ Yes	☐ No
Aquaphor Ointment for chapped lips	☐ Yes	☐ No
Baby Wipes (hypoallergenic, fragrance free, alcohol free)	☐ Yes	☐ No
Diapers and Pull-ups	☐ Yes	☐ No
Saline to rinse eyes	☐ Yes	☐ No
First Aid treatment for minor injuries	☐ Yes	☐ No

Parent Signature _____ Date _____

Form received _____(staff initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)

Form Revised: 7/8/19

Thrivalaska Head Start Birth to Five
Parental Consent Form – Non-Medical

Child's Printed Name: _____

I give permission for my child to be in a **class photo** or photo of classroom and field trip activities that may be given to other program children, families, or staff. ☐ **YES** ☐ **NO**

I give permission to Thrivalaska Head Start Birth to Five to utilize photographs of my child and family for use in publication materials including, but not limited to newsletters, brochures, flyers and displays in the program, classroom or community. ☐ **YES** ☐ **NO**

I give permission for my child and family's picture to be used in electronic media including, but not limited to program web site and news media. ☐ **YES** ☐ **NO**

I give permission for my **telephone number** to be given other program parents to inform me of events. ☐ **YES** ☐ **NO**

I give permission for my **address** to be given other program parents to inform me of events. ☐ **YES** ☐ **NO**

I give permission for my **child to attend field trips** and any other authorized activities as planned by the classroom staff. I also understand that parents/guardians will be notified of all field trips including the date, time, and destination before each trip. ☐ **YES** ☐ **NO**

Child and Family Wellness Consultation Services: ☐ **YES** ☐ **NO**
I give permission for my child to be observed by the Child and Family Wellness Consultant. This observation is used to assess classroom needs or the needs of my child. This will support your child's competency in all stages of development.

The following screenings will be conducted by a qualified specialist or Staff.
I give permission for the following:

Ages and Stages Questionnaire (ASQ): a screening tool used to assess infants and toddlers in the following areas: communication, gross motor, fine motor, problem solving, and personal and social development. The screening process is used to determine if developmental skills are progressing as expected, or if there is cause for further evaluation. Screenings will take place within 45 days of your child's enrollment. ☐ **YES** ☐ **NO**

Ages and Stages Questionnaire Social/Emotional Screening (ASQSE): ☐ **YES** ☐ **NO**
A screening tool to reflect the social and emotional competence of infants, toddlers, and preschool-age children

I understand my signature grants permission for the time my child is enrolled unless otherwise updated below.

Parent Signature _____ Date _____

Form received _____(staff initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)

Thrivalaska Head Start Birth to Five
Women, Infant & Children Program Information

Child's Printed Name: _____ DOB: _____

I give permission for Thrivalaska Head Start staff to obtain the following from the WIC Office as indicated. This information will be used for a Nutritional Assessment.

✘ HGB _____ (date and results (as applicable)) ✘Height _____ (date and results) ✘Weight _____ (date and results)

Other Dietary Related Information _____

_____

☐ My child is not currently enrolled or participating in the WIC program for the following reasons. _____

☐ I would like information about enrolling in a WIC Program.

My child is currently enrolled with:

☐ RCPC WIC Program 726 26th Ave
Phone (907) 456-2990 / Fax (907) 456-2980

☐ TCC WIC 1717 West Cowles St. Fairbanks, AK 99701
Phone (907) 451-6682 ext. 3778 /Fax (907) 455-3921

I understand that this signature grants permission for the time my child is enrolled or otherwise updated below.

Parent Signature _____ Date _____

Form received _____(staff initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)

Form Revised: 7/8/19

Thrivalaska Head Start Birth to Five
Early Head Start Child Nutrition Questionnaire

Child's Name: _____ Date of Birth:_____Age:_____

1. Please check item that currently describes your child's nutritional needs:
☐ Breast milk: how often?_____ ounces per feeding:_____ bottle____ breast____ both
☐ Formula: how often? _____ ounces per feeding:_____Type:_____

2. Does your baby drink from a ☐ bottle or ☐ sippy cup.

3. Does your baby have acid reflux or spit up often? ☐ Yes ☐ No
If yes, does your child receive medication for reflux or have special feeding instructions from their doctor? Please describe: _____

4. Special instructions during feeding time (ex: likes formula room temp, warm, etc.):
_____

5. Does your baby eat baby cereal? (must be able to eat from a spoon)
☐ Rice ☐ Barley ☐ Oats ☐ Mixed grains

6. Has your baby started eating baby food? ☐ Yes ☐ No
Foods your baby is currently eating: (List types of veggies, fruits, meats)

_____

7. Does your baby eat table foods? ☐ Yes ☐ No
Table foods your baby eats:_____

8. Does your baby have any medically diagnosed food sensitivities, food allergies, or disability that would require special diet? ☐ Yes ☐ No
If yes, please describe: _____
***Please provide a doctor's instruction for food substitutions and complete a Classroom Care Plan.

9. Are there any foods your baby should not eat for religious, cultural or health reasons? ☐ Yes ☐ No
If yes, please describe: _____

10. Do you have any other concerns about your baby's nutrition ☐ Yes ☐ No
____I have concerns about my baby's nutrition and feeding practices and would like the dietitian to call me.

11. Do you run out of money or Food Stamps to buy food? ☐ Yes ☐ No ☐ Sometimes

If you have a current question or concern about your child and their nutrition, would you like the Head Start Nutritionist to give you a call? ☐ Yes ☐ No

**If you would like to speak to the Head Start Nutritionist at any time in the future, please contact your teacher or family advocate.

Person Completing Form_____

Form received _____(staff initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)
Updated _____ (parent initials/date) Entered in CP _____ (staff initials/date)

Form Revised: 7/8/19

STATE OF ALASKA DIVISION OF PUBLIC HEALTH
SECTION OF PUBLIC HEALTH NURSING
TB Risk Assessment Questionnaire

If the answer to **any** question is "YES" a Tuberculin Skin Test (PPD) should be placed.
Verbal Screenings **must** be done on all EPSDT exams at 6, 12 & 24 months & 3, 4, 5 years.

Child's Name_____ DOB_____

Parent/Guardian Name _____

Has the child been in contact with anyone who has active TB disease?	YES ☐ NO ☐	YES NO	YES NO
Has the child had any international travel? (Other than W. Europe/Australia/NZ/Canada)	YES ☐ NO ☐	YES NO	YES NO
Was child born in a foreign country? (Any countries other than U.S., Canada, Australia, New Zealand, or Western/Northern Europe)	YES ☐ NO ☐	YES NO	YES NO
In Alaska TB is most common in the Yukon Kuskokwim or Norton Sound Region. Has the child traveled or lived in the Yukon Kuskokwim or Norton Sound Region of Alaska?	YES ☐ NO ☐	YES NO	YES NO
Does the child have HIV/AIDS or Immune System disorders?	YES ☐ NO ☐	YES NO	YES NO
	Date/Parent Initial	Date/Parent Initial	Date/Parent Initial

Circle Appropriate Finding:

Complete *Negative Risk Assessment*

Needs PPD Test *Positive Risk Assessment*

Form received _____(staff initials/date)
Updated _____ (parent initials/date)
Updated _____ (parent initials/date)

Entered in CP _____ (staff initials/date)
Entered in CP _____ (staff initials/date)
Entered in CP _____ (staff initials/date)

Form Revised: 7/8/19