

Thank you for your interest in the Head Start / Early Head Start Program. Our program offers part day and full day preschool and family services in various locations throughout Santa Clara and San Benito Counties.

To qualify for our services your child must be age eligible AND your family must either be income or categorically eligible.

ELIGIBILITY REQUIREMENTS

Age Eligibility: For Head Start - Your child must turn 3 yrs old AND must not turn 5 yrs old by December 2nd
 For Early Head Start – Your child must be at least 18 months and not yet 3 yrs old

Income Eligibility: Your family is income eligible if your income meets the 2009 Federal Income Guidelines listed below:

SIZE OF FAMILY UNIT	GROSS ANNUAL INCOME
1	\$ 10,830
2	\$ 14,570
3	\$ 18,310
4	\$ 22,050

SIZE OF FAMILY UNIT	GROSS ANNUAL INCOME
5	\$ 25,790
6	\$ 29,530
7	\$ 33,270
8	\$ 37,010

For family units with more than 8 members, add \$3,740 for each additional member.

Categorical Eligibility: Your family is eligible if you are in any of the following categories

- The child to be enrolled is in foster care
- The family is receiving benefits or services through the CalWORKs Program
- A family member living with and supported by you is receiving Supplemental Security Income benefits (SSI)
- The family is homeless

Children with disabilities: You may be eligible for Head Start if your child has a current Individualized Education Plan (IEP) or for Early Head Start if your child has a current Individual Family Service Plan (IFSP). With a current IEP/IFSP, you may not need to be income eligible.

REQUIRED DOCUMENTS

Your application must be complete and include copies of the following documents (**documents will not be returned**):

- **Birth Certificate**
- **Immunization Records**
- **TB Assessment and/or TB Test Results**
- **Income Verification** – Documentation of all sources of income received by the child’s parents or guardians such as:

✓ Current pay stubs (within the last month) showing one month of income	✓ Unemployment Income
✓ Letter from employer stating hours worked per week and pay rate	✓ Worker’s Compensation
✓ Latest Income Tax Return	✓ Child Support
✓ Latest W-2	✓ Disability Income
- **Proof of Legal Custody** (if child is in foster care)
- **Notice of Action** (if receiving CalWORKs)
- **Proof of Supplemental Security Income** (if applicable)
- **Homelessness Verification** (if applicable and available)
- **Current IEP** (Head Start) **or IFSP** (Early Head Start) (if applicable)
- **Full Time Employment or School/Training Verification** (if you are requesting full day services)

SUBMITTING YOUR APPLICATION

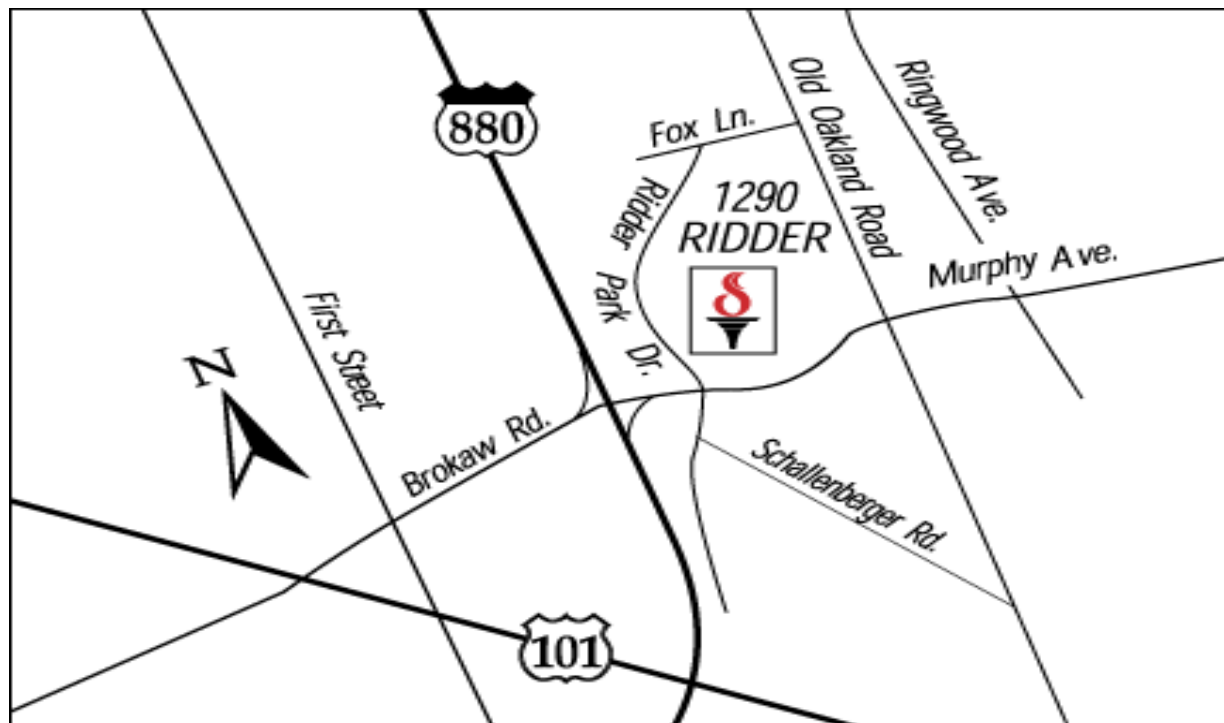
Once you have completed the application, you may submit your materials in one of the following ways:

- ✓ Call the office to ask for directions to the center nearest you
- ✓ Deliver in person or Mail to: Head Start Program, 1290 Ridder Park Drive, MC 225, San Jose, CA 95131-2304

You will be contacted by mail once your application has been processed.

If you have any questions please call (408) 453-6900 or (800) 820-8182, Monday through Friday, 8:00 a.m. to 5:00 p.m.

SCCOE RIDDER PARK MAP



The Santa Clara County Office of Education is located at 1290 Ridder Park Drive, San Jose, CA 95131-2304, just off Highway 880 at the corner of Brokaw Road and Ridder Park Drive.

There are several routes you may take to reach our office.

If you are coming from Sunnyvale: Take Highway 101 (south to San Jose) to the First Street/Brokaw Road exit. Stay in the far left lane and turn left onto Brokaw. Continue east on Brokaw for 1.3 miles, then turn left onto Ridder Park Drive. Take the first right into the County Office parking lot.

If you are coming from North San Jose: Take Highway 880 (south towards San Jose) to the Brokaw Road exit; stay in the left lane and turn left onto Brokaw Road. Continue east on Brokaw (through one more stoplight), move into the left turn lane and take a left onto Ridder Park Drive. Take the first right into the County Office parking lot.

If you are coming from San Jose or South County: Take Highway 101 (north to San Francisco); exit at Highway 880 North (towards Oakland) and in about one mile exit at the Brokaw Road. Turn right (east) onto Brokaw Road; move into the left lane. Turn left onto Ridder Park Drive. Take the first right into the County Office parking lot.

- Or -

Take Highway 880 North to the Brokaw Road exit. Turn right (east) onto Brokaw Road; move into the left lane. Turn left onto Ridder Park Drive. Take the first right into the County Office parking lot.

HEAD START / EARLY HEAD START ENROLLMENT APPLICATION

PLEASE PRINT LEGIBLY USING BLACK OR BLUE INK ONLY

OFFICE USE ONLY: Tracker# _____

Child (Applicant)				
First Name	Last Name	Middle	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/American Indian/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> Other:			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
English Proficiency of the Child <input type="checkbox"/> None <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient				
Does the child have a current IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please also complete the Disabilities questions on page 6				

Family Information				
Head of Household's Name			Relationship to Child	
Mother/Guardian's Name	Birth Date / /	Father/Guardian's Name	Birth Date / /	
Living Address		City/ Zip		<input type="checkbox"/> Family is currently homeless
Mailing Address (if different)		City/ Zip		
Home Phone <input type="checkbox"/> Primary phone	Cell Phone	<input type="checkbox"/> Primary Phone	Work Phone	<input type="checkbox"/> Primary Phone
Parents/Guardians in the Home <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents	Name of Person Having Legal Custody of the Child		Is the child in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the child living with a relative or friend due to incarceration or abandonment? (excluding foster children)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Language Spoken at Home <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____				
Do you or a family member living with and supported by you receive Supplemental Security Income benefits (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Does the child (applicant) have a sibling with a current IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No				

List all other family members living in the household for whom you are responsible for the care and welfare of:

First Name	Last Name	Birth Date	Is this person related to the child's parent(s)?	Is this person supported by the parent's(s) income?
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Total number of people living in the household (including you) for whom you provide financial support

Other family members or friends we can contact in case we are unable to reach you

Name	Phone	Relationship
Name	Phone	Relationship

HEAD START / EARLY HEAD START ENROLLMENT APPLICATION

Child's Name _____

Birth Date _____

Mother/Guardian			
First Name		Last Name	
Birth Date / /	Lives with Child Y N	Legal Custody Y N	Has Income Y N
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Do you receive Child Support? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per month \$			
Highest Level of Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree			
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Disabled <input type="checkbox"/> Incapacitated Dates of Incapacity From _____ To _____			
Employer Name		Employer Phone	
Employer Name		Employer Phone	
Work Schedule (Include all jobs)			
Monday _____		Thursday _____	
Tuesday _____		Friday _____	
Wednesday _____		Sat/Sun _____	
Total Hours Per Week: _____			
Pay Days are <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Monthly			
Gross Income \$ _____ Per _____			
Do you receive CalWORKs (TANF)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per month \$			
Do you have any other sources of income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per month \$ Description:			
Are you in School or Training? <input type="checkbox"/> Yes <input type="checkbox"/> No			
School Name		School Phone	
School or Training Schedule Units _____			
Monday _____		Thursday _____	
Tuesday _____		Friday _____	
Wednesday _____		Sat/Sun _____	
Total Hours Per Week (class time only) _____			
Are you an employee of SCCOE Head Start?		Y	N
Are you related to an SCCOE Head Start employee?		Y	N

Father/Guardian			
First Name		Last Name	
Birth Date / /	Lives with Child Y N	Legal Custody Y N	Has Income Y N
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Do you receive Child Support? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per month \$			
Highest Level of Education <input type="checkbox"/> Less than High School <input type="checkbox"/> Some College or AA/AS <input type="checkbox"/> High School Grad or GED <input type="checkbox"/> Bachelor's or Advanced Degree			
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Seasonally Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Disabled <input type="checkbox"/> Incapacitated Dates of Incapacity From _____ To _____			
Employer Name		Employer Phone	
Employer Name		Employer Phone	
Work Schedule (Include all jobs)			
Monday _____		Thursday _____	
Tuesday _____		Friday _____	
Wednesday _____		Sat/Sun _____	
Total Hours Per Week: _____			
Pay Days are: <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice Per Month <input type="checkbox"/> Monthly			
Gross Income \$ _____ Per _____			
Do you receive CalWORKs (TANF)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per month \$			
Do you have any other sources of income? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount per month \$ Description:			
Are you in School or Training? <input type="checkbox"/> Yes <input type="checkbox"/> No			
School Name		School Phone	
School or Training Schedule Units _____			
Monday _____		Thursday _____	
Tuesday _____		Friday _____	
Wednesday _____		Sat/Sun _____	
Total Hours Per Week (class time only) _____			
Are you an employee of SCCOE Head Start?		Y	N
Are you related to an SCCOE Head Start employee?		Y	N

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing childcare services.

Parent/Guardian's Signature _____

Date _____

HEAD START / EARLY HEAD START ENROLLMENT APPLICATION

Child's Name _____

Birth Date _____

HEALTH INFORMATION AND HISTORY

Doctor's Name (Medical Home)	Phone ()	Address	City	Zip
Dentist's Name (Dental Home)	Phone ()	Address	City	Zip
Dental Insurance	Phone ()	Address	City	Zip

Health Coverage: Medi-Cal/Medicaid Healthy Families California Healthy Kids Private Other _____

Are you receiving services from WIC - ID # _____

Other Health Coverage

IMMUNIZATIONS

Before your child is placed on a class list, copy of your child's current immunization records must be received by the program according to the State of California Immunizations requirements. All immunizations must be recorded by showing a date given and signature or stamp verification by health care provider. If your child does not have an immunization record or has not received all required immunizations, call your health care provider as soon as possible to obtain a record or make an appointment for your child to receive these immunizations.

REQUIRED HEALTH ASSESSMENT (PHYSICAL EXAM)

A health assessment (physical examination) by a physician is required. This exam must include Hemoglobin/Hematocrit (blood work), Hearing and Vision Screenings, Height & Weight, TB Assessment and/or test if at risk, Tobacco, and Lead Test. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor within 30 days of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Child Health Assessment form).

Is a copy of a current Physical Exam included with application? Yes No Date of child's last physical exam _____

REQUIRED DENTAL EXAM (FOR PRESCHOOL CHILDREN AGES 3-5 YEARS OLD ONLY)

A dental exam by a dentist is required. If you do not have a copy of a current dental exam for your child, you will be asked to take your child to the dentist within 90 days of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Dental Examination form).

Is a copy of a current Dental Exam included with application? Yes No Date of child's last dental visit _____

MEDICATIONS

LIST ALL MEDICINES, PRESCRIPTIVE AND NON-PRESCRIPTIVE, THAT YOUR CHILD TAKES REGULARLY

Your child will not be given medication at school without a physician's note and a Classroom Health Plan written with the parent and program staff.

ALLERGIES AND SPECIAL DIET

CIRCLE ONE

LIST ALL ALLERGIES (FOOD OR OTHER)

Yes No

List special diets to accommodate for cultural preference or for religious reasons (indicate what specific foods are included)

Yes No

A Classroom Nutrition Plan will be written with the parent and program staff to address all allergies and special diets.

NUTRITION INFORMATION

Does your child experience any of the following symptoms after eating? Diarrhea Itching
 Vomiting Difficulty Swallowing

Does your child eat Dirt Clay Paint Chips Ice Chips Refrigerator Frost
 Cornstarch Laundry Starch School Paste Pencils

Child's Name _____

Birth Date _____

SPECIAL HEALTH NEEDS / CHRONIC ILLNESS				CIRCLE ONE		
Asthma				Yes	No	
Anemia				Yes	No	
Diabetes				Yes	No	
Pediatric First Aid Needs				Yes	No	
Other Special Health Needs				Yes	No	
BIRTH HISTORY						
Was your child premature?		Yes	No	While in the hospital, did your child have yellow jaundice?		
Was your child exposed to cigarette smoke?		Yes	No	Yes	No	
EARS AND EYES						
Any trouble hearing?		Yes	No	Any trouble with his/her eyes?		
Use a hearing device?		Yes	No	Has your child ever worn glasses?		
If yes, to any of the above, please explain						
FAMILY HISTORY						
Mother's Health Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			Father's Health Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
While pregnant did the mother drink alcoholic beverages that affected the development of the child?			Yes	No	While pregnant did the mother take any drugs that affected the development of the child?	
			Yes	No	Yes	No
If yes, to any of the above, please explain:						
Has your child been exposed to second hand smoke? Yes No						
SOCIAL – EMOTIONAL DEVELOPMENT						
Does your child have			Does your child have			
Problems getting along with other children the same age?			Yes	No	Aggressive behavior?	
			Yes	No	Yes	No
Problems getting along with other family members?			Yes	No	Extreme shyness?	
			Yes	No	Yes	No
Problems sleeping?			Yes	No	Problems separating from parent/guardian?	
			Yes	No	Yes	No
Temper tantrums?			Yes	No	Other concerns you may have about your child's behavior	
			Yes	No		
Severe fears?			Yes	No		
			Yes	No		
Currently receiving mental health services?			Yes	No	If yes, agency name	
			Yes	No		
DISABILITIES						
Does your child have an Individualized Education Plan (IEP) with your local school district of residence or County Office of Education program? If yes, please attach copy of the most recent IEP.				Yes	No	
Does your child have an Individual Family Service Plan (IFSP) with an early intervention program, regional center, County Office of Education, or school district? If yes, please attach copy of the most recent IFSP.				Yes	No	
Additional information about your child's disability or other developmental concerns. Please explain if yes circled above						

PARENT CONSENT FOR PROGRAM SERVICES

I understand that Head Start is a comprehensive program that will provide many services to support my child and family. Classroom observations and screenings are part of the program, which enable staff to plan for my child's individual development. I understand that the program staff will keep me informed as each service is completed and provide, to me, the results of all procedures and services my child receives. I give permission for Head Start staff to complete the following with my child:

- Vision & Hearing Screenings
- Nutritional Assessment
- Height & Weight
- Dental Screening

Parent/Guardian's Signature _____

Date _____

Authorization to Release Records
COMPLETE AND RETURN THIS FORM

Child's Name _____ Birth Date _____

Parent/Guardian's Name _____

I hereby authorize the release of the following records to Preschool Services Department Head Start Program:

Physical examination, immunizations records (including a Tuberculosis Skin Test), dental examination and treatment plan, assessment reports, and Individualized Educational Plan (IEP) and/or Individual Family Service Plan (IFSP) from school districts or other agencies.

All release of information about my child will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Private Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2009; and Head Start Performance Standards (1301, 1304, 1305, and 1308).

I understand this information is strictly confidential and will be used to provide necessary services and to permit statistical reporting on the results of screenings. This authorization shall be valid for one year from date it is signed.

Parent/Guardian's Signature

Date

Authorization to Share Records
COMPLETE AND RETURN THIS FORM

Child's Name _____ **Birth Date** _____

Parent/Guardian's Name _____

The Santa Clara County Office of Education Head Start / Early Head Start Program has established partnerships with other child care agencies to be able to provide quality child care and family services to a larger number of children and families. If you allow us to share your enrollment application and pertinent information with our child care partners it could help us to find an opening for your child sooner. Children and families served by our child care partners receive all of the same benefits of a high quality Head Start or Early Head Start experience as is available in our directly operated classrooms.

If you consent to this release you may be contacted by one of our child care partner agencies about enrollment opportunities in their program.

Child Care Partners of the SCCOE Head Start / Early Head Start Program:

- East Side Union High School District Child Development Program (Early Head Start)
- Kidango, Inc.
- Mountain View/Whisman School District
- Parkway Child Development Programs
- SJB Child Development Center

All release of information will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Privacy Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2009; and Head Start Performance Standards (1301, 1304, 1305, and 1308).

- Yes, I authorize the release of my child's enrollment application and pertinent information to be sent to child care partner agencies to facilitate the enrollment of my child into a preschool program.
- No, I do not authorize the release of my child's enrollment application and pertinent information to be sent to child care partner agencies.

Parent/Guardian's Signature

Date

Dental Examination

Child's Name _____ Birth Date _____

Center Name _____ Enrollment Date _____

Parent/Guardian's Name _____

I hereby authorized Head Start Staff to contact the dental provider of the above-named child for information needed to complete this form.

Parent/Guardian's Signature _____ Date _____

Dear Dental Provider:

Please fill out this form completely, sign, and return to the child's parent/guardian listed above. If the child requires more than a routine check-up, we will require information when the initial examination is done and when treatment has been completed. ***Please note: when routine care is provided by a hygienist, Head Start guidelines require a dentist signature to ensure that care has been provided.***

Date of most recent examination _____

- Child received cleaning and fluoride application
- Child had x-rays taken
- Was child prescribed fluoride Yes No

- Results:**
- Class I Is treatment required at this time Yes No
 - Class II Mild dental problems
 - Class III Severe dental problems
 - Class IV Emergency dental treatment required

Appointment date for treatment _____

Dentist's signature and stamp required _____

Name, phone number, and address of dentist _____

Complete this section only if treatment is required

Summary of Treatment:

- Treatment completed Yes No Date _____
- If treatment is not completed, appointment date _____
- Filling of teeth
- Extraction of non-restorable teeth
- Restoration of decayed teeth
- Referred to doctor _____
- Other _____

Dentist's signature _____

CHDP Dental Providers

Cyrus M. Akhbari
Pediatric Dentistry
1201 Park Avenue, Suite 2
San Jose, CA 95126
(408) 971-9990
Spanish/Vietnamese/Tagalog

Comprecare Dental
3030 Alum Rock Avenue
San Jose, CA 95127
(408) 254-5185
Spanish/Hindi

Evergreen Dental Group
2451 S. King Road, Suite A
San Jose, CA 95122
(408) 274-9600
Spanish/Tagalog

Jackson Family Dental
2324 Montpelier, Suite 3
San Jose, CA 95116
(408) 937-5950
Spanish/Chinese

Lucky Dental
2003 Story Road, Suite 800
San Jose, CA 95122
(408) 928-6000
Spanish/Chinese

Son A. Tran
260 Aborn Road, Suite 180
San Jose, CA 95121
(408) 239-0816
Vietnamese

City Dental Center
7671 Monterey Road, Suite G
Gilroy, CA 95020
(408) 842-5000
Spanish/Farsi

South Valley Dental Clinic
90 Highland Avenue
San Martin, CA 95046
(408) 808-6102
Spanish

Children's Dental Center
1153 South King Road
San Jose, CA 95122
(408) 240-0250
Spanish

Dental Image
Adrienne N. Lan Van
2114 Senter Road, Suite 14
San Jose, CA 95111
(408) 298-8187
Vietnamese

Khalsa Dental Care
2850 Quimby Road, Suite 145
San Jose, CA 95148
(408) 274-5000
Spanish/Vietnamese/Filipino

Andre Metcalf
645 Wool Creek Drive
San Jose, CA 95112
(408) 283-6200
Spanish

Tully Dental Center
500 Tully Road
San Jose, CA 95111
(408) 808-6102
Spanish

Devinder S. Shoker
2133 Morrill Avenue
San Jose, CA 95132
(408) 945-0411
Spanish/Vietnamese/Hindi

Asadi H
3535 Ross Avenue, Suite 105
San Jose, CA 95124
(408) 267-4690
Spanish

Western Dental Center
Accepts all types of Medical and
children as young as 1 year old
Call to make an appointment at
1(800) 466-5555 ext 3304
Spanish

Capitol Square Dental
Ramon R. Ocampo
2727 McKee Road
San Jose, CA 95127
(408) 259-5545
Spanish/Tagalog

First Choice Dental
967 McLaughlin Avenue
San Jose, CA 95122
(408) 258-9943
Spanish/Tagalog

Daisy G. Ison
2340 McKee Road, Suite 22
San Jose, CA 95116
(408) 272-8855
Spanish/Tagalog

Duong Chi Nguyen
1175 E. Julian Street, Suite 203
San Jose, CA 95112
(408) 298-1221
Vietnamese

Lawrence Tottori
2180 Story Road, Suite 101
San Jose, CA 95122
(408) 259-7772
Spanish/Vietnamese/Chinese

Maria Villar
Willow Dental Health Center
283 Willow Street
San Jose, CA 95110
(408) 298-6411
Spanish

San Jose Dental Surgery Center
1998 Alum Rock Avenue
San Jose, CA 95116
(408) 240-9000
Vietnamese

South County Dental Center
Gardner Health
700 West 6th Street, Suite E
Gilroy, CA 95050
(408) 846-6473
Spanish

CHILD HEALTH ASSESSMENT REPORT – CONFIDENTIAL

Medi-Cal / CHDP / Medical Providers:

Please complete Confidential Screening and return to parent/guardian in the Head Start / Early Head Start Program.

Child's Last Name:	First name	Initial	Sex M F	Birth Date	Month	Day	Year
--------------------	------------	---------	---------------	------------	-------	-----	------

SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

<p>AUTHORIZATION FOR RELEASE OF INFORMATION/ AUTORIZACIÓN PARA REVELAR INFORMACIÓN /LỜI CHO PHÉP QUẢNG BÁ CHI TIẾT I authorize release of medical information contained in this report to the Head Start Program / Yo autorizo a que la información médica que aparece en este informe sea revelada al Programa Head Start / Tôi cho phép quảng bá các chi tiết y khoa ở trên bản báo cáo này đến Chương Trình Head Start.</p>	
SIGNATURE OF PARENT OR GUARDIAN / FIRMA DEL PADRE O TUTOR/PHỤ HUYNH HOẶC GIÁM HỘ KÝ TÊN	DATE/FECHA/NGÀY

HEALTH CARE PROVIDER MUST COMPLETE ALL ITEMS BELOW

The Santa Clara County Office of Education administers a Head Start Program which is federally funded. Federal regulations require that a health professional make a determination as to whether a child is up to date on a schedule of age appropriate health assessments and screenings.

Date of Service Month Day Year	Child's Age Years Months	Allergies:			
Height/Length (Inches)	Weight (Pounds)	Blood Pressure (3 & 4 Yr olds only) / BP Elevated _____	Vision Chart Exam OD _____ OS _____ OU _____ Corrected / Uncorrected	Temp: _____ Pulse: _____ Resp: _____	Head Circumference (Inches): _____
Please indicate outcome for each screening procedure (Refer to Periodicity Schedule on reverse of form)		No Problem Suspected ✓	Problem Suspected ✓	Comments / Problems If a problem is diagnosed on this visit, please enter diagnosis, treatment plan, and special care instructions or restrictions this area.	
History and Physical Exam					
Dental Assessment/Referral					
Nutrition Assessment					
Develop/Behavioral Assessment					
Anticipatory Guidance					
Tobacco Assessment					
Language/Speech				If tests were not done, please explain why?	
Hemoglobin or Hematocrit Review Annually		Hgb Values Date: _____	Hct Values Date: _____		
Blood Lead Level (BLL) required at 12 and 24 months; Test at 24-72 months if not tested previously		BLL Value: Date: _____	Need status of BLL Value: <input type="checkbox"/> Verbal Risk Assessment Completed (Must be checked)		
Urine Dipstick or Urinalysis (for 4 year olds only)		Results: _____ Date: _____			
Hearing Screening * Non-Audiometric (under 3 years) <input type="checkbox"/>		Results: <input type="checkbox"/> Pass	<input type="checkbox"/> Unable/Uncooperative		
Vision Screening * Clinical Observation (under 3 years) <input type="checkbox"/>		Results: <input type="checkbox"/> Pass	<input type="checkbox"/> Unable/Uncooperative	<input type="checkbox"/> Re-screen	
Tuberculin Verbal Risk Assessment required 0-60 months		<input type="checkbox"/> Verbal Risk Assessment Completed (Must be checked) Please check: <input type="checkbox"/> Low Risk <input type="checkbox"/> High Risk			
TB Test Required		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date Given: _____	Date Read: _____	Results in millimeters: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Patient Needs Immunizations <input type="checkbox"/> Yes <input type="checkbox"/> No					
Given today:		Polio (OPV or IPV) _____ Hepatitis B _____	DTP _____ Varicella _____	MMR _____ PCV _____	HIB _____ Other _____
Provider of Service (Please include name, address and telephone number):			Referred to:		Telephone Number
Signature of Provider			Date		

HEAD START / EARLY HEAD START PERIODICITY SCREENING GUIDELINES

PM 160 INSTRUCTION

Note: These guidelines follow the recommendations of the Centers for Disease Control and Prevention (CDC) and the Child Health and Disabilities Prevention (CHDP) Program.

PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS

Screening Requirement	Age of Person Being Screened										
	Under 1 mo.	1-2 mos.	3-4 mos.	5-6 mos.	7-9 mos.	10-12 mos.	13-15 mos.	16-23 mos.	2 Yr.	3 Yr.	4-5 Yr.
Interval Until Next Exam	1 mo.	2 mos.	2 mos.	2 mos.	3 mos.	3 mos.	3 mos.	6 mos.	1 yr.	1 yr.	2 yr.
History & Physical Examination	•	•	•	•	•	•	•	•	•	•	•
Dental Assessment	•	•	•	•	•	•	•	•	•	•	•
Nutritional Assessment	•	•	•	•	•	•	•	•	•	•	•
Developmental/Behavioral	•	•	•	•	•	•	•	•	•	•	•
Anticipatory Guidance	•	•	•	•	•	•	•	•	•	•	•
Tobacco Assessment	•	•	•	•	•	•	•	•	•	•	•
Measurements											
Head Circumference	•	•	•	•	•	•	•	•			
Height/Length and Weight	•	•	•	•	•	•	•	•	•	•	•
Blood Pressure										•	•
Sensory Screening											
Visual Acuity Test (Snellen) ²										•	•
Clinical Observation	•	•	•	•	•	•	•	•	•	•	•
Audiometric ²										•	•
Non-audiometric	•	•	•	•	•	•	•	•	•	•	•
Procedures / Tests											
Tuberculin Test											•
TB Exposure Risk Assessment	•	•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin					•		•		•	•	•
Urine Dipstick or Urinalysis											•
Blood Lead Test						•			•		
Blood Lead Risk Assessment				•	•	•	•	•	•	•	•
Other Laboratory TESTS											
VDRL, RPR, or ART	To be done when health history and/or physical examination warrants.										
Gonorrhea Test	To be done when health history and/or physical examination warrants.										
Chlamydia Test	To be done when health history and/or physical examination warrants.										
Papanicolaou (Pap) Smear	To be done when health history and/or physical examination warrants.										
Sickle Cell	To be done when health history and/or physical examination warrants.										
Ova and Parasites	To be done when health history and/or physical examination warrants.										
Immunizations	Administer as necessary to make status current										

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

1. Snellen testing and audiometric testing should start at age 3 years if possible. Clinical observation and nonaudiometric testing may be substituted if child is uncooperative.

Pediatric Primary Care Providers

Santa Clara Valley Health and Hospital System

Call Valley Connection at 1 (800) 334-1000 to make an appointment at one of the following health centers:

Valley Health Center Bascom

750 South Bascom Avenue
San Jose, CA 95128

Valley Health Center Tully

500 Tully Road
San Jose, CA 95111

Valley Health Center East Valley

1993 McKee Road
San Jose, CA 95116

Valley Health Center Silver Creek

1620 East Capitol Expressway
San Jose, CA 95121

Valley Health Center Fair Oaks

660 South Fair Oaks Avenue
Sunnyvale, CA 94086

Valley Health Center San Martin

90 Highland Avenue
San Martin, CA 95046

Community Clinics / Health Centers:

Asian Americans for Community Involvement

2400 Moorpark Avenue, Suite 319
San Jose, CA 95126
(408) 975-2763

Franklin-McKinley Neighborhood Clinic

645 Wool Creek Drive
San Jose, CA 95112
(408) 283-6051
(408) 975-2730

Gilroy Neighborhood Health Clinic

7861 Murray Avenue
Gilroy, CA 95020
(408) 842-1017

Indian Health Center

1333 Meridian Avenue
San Jose, CA 95125
(408) 445-3400

San Jose Foothill Family Community Clinic

660 Sinclair Drive
San Jose, CA 95116
(408) 729-4282

Washington Neighborhood Health Clinic

100 Oak Street
San Jose, CA 95110
(408) 295-0980

Gardner Family Health Network:

CompreCare Health Center

3030 Alum Rock Avenue
San Jose, CA 95127
(408) 259-8400

Gardner Health Center

195 East Virginia Street
San Jose, CA 95112
(408) 918-5500

St. James Health Center

55 East Julian Street
San Jose, CA 95112
(408) 918-2600

Gardner South County Health Center

7526 Monterey Street
Gilroy, CA 95020
(408) 848-9400

Mayview Community Health Centers:

Columbia Neighborhood Center

785 Morse Avenue
Sunnyvale, CA 94085
(408) 523-8150

Mayview Community Health Center at Mountain View

100 North Moffett Blvd., Suite 101
Mt. View, CA 94043
(650) 965-3323

Planned Parenthood:

Planned Parenthood, Blossom Hill

5440 Thornwood Drive, Suite G
San Jose, CA 95123
(408) 281-9777

Planned Parenthood, San Jose

1691 The Alameda
San Jose, CA 95126
(408) 287-7526

Mar Monte Community Clinic

2470 Alvin Avenue, Suite 80
San Jose, CA 95121
(408) 274-7100

Planned Parenthood, Sunnyvale

604 East Evelyn Avenue
Sunnyvale, CA 94086
(408) 739-5151

Planned Parenthood, Mt View

225 San Antonio Road
Mt. View, CA 94040
(650) 948-0807

South County

Hazel Hawkins Community Health Clinic

930 Sunset Drive, Building 3
Hollister, CA 95023
(831) 636-2664

Office hours

Mon - Fri – 8:00 am – 8:00 pm
Saturday - 8:15 am – 5:00 pm
Sunday – 8:15 am – 12:00 noon

To apply for free or low cost children's health insurance call:

Children's Health Initiative – 1 (800) 234-1317 or 1 (888) 244-5222

Child Health & Disability Prevention Program – (408) 494-7410

Medi-Cal Eligibility – (408) 271-5600