ELKHART AND ST. JOSEPH COUNTIES HEAD START CONSORTIUM
HEALTH CLASSROOM FILE CHECKLIST
2023-2024

Child's Name: _____ Enrollment Date: ___ / ___ /_____

Health:

_____ Application Health Checklist

_____ Participant Health summary 3030 (**Signed by the Nurse**)

_____ Healthcare Plan ( ) Yes ( ) No

_____ Permission for Medication ( ) Yes ( ) NO

Medication Expiration Date: _____

_____ Food Allergies ( ) Yes ( ) NO (**Signed by Registered Dietician**)

_____ Health Requirements letter follow-up

_____ Breast Feeding Procedure and Consent (if applicable)

_____ Physical Date completed: ___/___/_____ Date Expires: ___/___/_____

_____ Birth Record (EHS/EHS-CCP)

_____ Blood Pressure

_____ Hgb results _____ Date Completed: ___/___/_____ Treatment- Follow Up ___/___/_____

_____ Sickle Cell (EHS/EHS-CCP)

_____ Lead results _____ Date Completed: ___/___/_____ Treatment- Follow Up ___/___/_____

_____ TB Questionnaire

_____ Dental: ___/___/_____ Treatment-Follow Up ___/___/_____

_____ Immunizations (**Print Report 3320**)

_____ Health History/Nutrition Assessment