



PARENT NOTIFICATION OF MEDICAL/DENTAL SCREENINGS AND EXAMS RESULTS

Child's Name: _____

Your child has been screened and/or examined for:

	Results:		
MEDICAL:	No problems were found	In need of another screening	Needs to see a specialist or have treatment*
_____ Hearing: Your child's hearing was checked to make sure he/she hears well.	_____	_____	_____
_____ Vision: Your child's eyes were checked to make sure he/she sees well.	_____	_____	_____
_____ Hemoglobin/Hematocrit: A sample of your child's blood was taken to check for anemia.	_____	_____	_____
_____ Lead: A sample of your child's blood was taken to check for lead exposure.	_____	_____	_____
_____ TB Skin Test: A small injection was given under the skin to check if there were any conditions that might hinder his/her ability to grow and learn normally.	_____	_____	_____
_____ Physical: Your child was examined by a doctor or nurse practitioner to check if there were any conditions that might hinder his/her ability to grow and learn normally.	_____	_____	_____
_____ Other: _____			

DENTAL:	No problems were found	In need of dental treatment *
_____ Dental Exam: A dentist checked your child's teeth to see if there were any cavities or problems that may need treatment.	_____	_____
_____ Cleaning/Fluoride: Your child's teeth were cleaned and fluoridated by a hygienist or dentist.	_____	_____

 Signature of Head Start Staff

 Date

* If a check appears in the column with an asterisk, you will be contacted to give consent before any treatment is done.

Complete and send to parents within 3 days of each procedure or when results are received.