

HEALTH DATA TRACKING INSTRUMENT

HEAD START CENTER _____

ADDRESS _____

YEAR _____ CLASS _____ SHEET _____ OF _____

Record dates in spaces above boxes. REFER TO INSTRUCTIONS.

Key:

"STANDARD TESTS" AND "TESTS AS APPROPRIATE"

- | | | | |
|---|-----|---|---|
| s | p/r | d | t |
|---|-----|---|---|

 Services or procedures not performed.
- | | | | |
|-------------------------------------|-----|---|---|
| <input checked="" type="checkbox"/> | p/r | d | t |
|-------------------------------------|-----|---|---|

 Results of this screening SUSPECT, re-screening required.
- | | | | |
|-------------------------------------|-----|---|---|
| <input checked="" type="checkbox"/> | p/r | d | t |
|-------------------------------------|-----|---|---|

 This screening or re-screening completed, results NORMAL.
- | | | | |
|-------------------------------------|-------------------------------------|---|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | d | t |
|-------------------------------------|-------------------------------------|---|---|

 This screening or re-screening completed. Results ATYPICAL/ABNORMAL, referral for diagnosis needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | t |
|-------------------------------------|-------------------------------------|-------------------------------------|---|

 Referral arranged, diagnosis needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Diagnosis complete, no treatment required.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Diagnosis complete, treatment required.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Treatment begun.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Treatment complete or ongoing problem management assured.

Check all services paid by Medicaid/EPST. REFER TO INSTRUCTIONS.

MEDICAL EXAMINATION

- | | | | |
|---|-----|---|---|
| e | p/r | d | t |
|---|-----|---|---|

 Services or procedures not performed.
- | | | | |
|-------------------------------------|-----|---|---|
| <input checked="" type="checkbox"/> | p/r | d | t |
|-------------------------------------|-----|---|---|

 Examination completed, all results normal.
- | | | | |
|-------------------------------------|-----|---|---|
| <input checked="" type="checkbox"/> | p/r | d | t |
|-------------------------------------|-----|---|---|

 Examination completed. Results indicate one or more possible problems. Referral needed.
- | | | | |
|-------------------------------------|-------------------------------------|---|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | d | t |
|-------------------------------------|-------------------------------------|---|---|

 Referral arranged, diagnosis needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | t |
|-------------------------------------|-------------------------------------|-------------------------------------|---|

 Diagnosis complete, no treatment needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Diagnosis complete, treatment needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Treatment begun.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Treatment complete, or ongoing problem management assured.

Check all services paid by Medicaid/EPST. REFER TO INSTRUCTIONS.

DENTAL SERVICES

- | | | | |
|---|---|---|---|
| e | t | c | f |
|---|---|---|---|

 Services or procedures not performed.
- | | | | |
|-------------------------------------|---|---|---|
| <input checked="" type="checkbox"/> | t | c | f |
|-------------------------------------|---|---|---|

 Examination completed, no further dental services needed.
- | | | | |
|-------------------------------------|-------------------------------------|---|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | c | f |
|-------------------------------------|-------------------------------------|---|---|

 Examination completed, treatment needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | f |
|-------------------------------------|-------------------------------------|-------------------------------------|---|

 Treatment initiated.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Treatment completed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Examination completed, cleaning needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Cleaning completed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Fluoride topical application or supplementation needed.
- | | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|

 Fluoride topical application or supplementation received.

Check all services paid by Medicaid/EPST. REFER TO INSTRUCTIONS.

IMMUNIZATIONS

- | | |
|---|---|
| s | i |
|---|---|

 Immunization status not determined.
- | | |
|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|

 Immunization status determined. One or more doses of this immunization needed.
- | | |
|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|

 One or more doses of this immunization series given, further doses needed. (Enter date latest dose given & date next dose needed)
- | | |
|-------------------------------------|-------------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
|-------------------------------------|-------------------------------------|

 Immunization (or series of doses) completed. (Enter date last dose given)

NOTE: You can use three (3) colors of ink to show when immunizations were completed. Mark the colors you are using in the spaces below to show your code.

Color Used

Before entering Head Start

Between start of operating period and Dec. 31, 19__

Between Jan. 1, 19__ and end of operating period

FUTURE CARE: Enter source of care and of funding the family plans to use after the child leaves Head Start.

ID. No.
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

HEALTH DATA TRACKING INSTRUMENT

PART B

- s = Screening
- p/r = Problem Referral
- d = Diagnosis
- t = Treatment
- e = Exam
- c = Dental Cleaning
- f = Dental Fluoride
- i = Immunization

- = Procedure or service not performed.
- = Procedure or service performed, follow-up (re-testing, referral, or treatment) needed.
- = Procedure or service begun.
- = Procedure or service completed.

HEAD START CENTER _____
 ADDRESS _____
 YEAR _____ CLASS _____ SHEET _____ OF _____

ID. No.	TESTS AS APPROPRIATE												Medical Exam	Dental Services																	
	TB			Lead			Sickle Cell								e	p/r	d	t	e	t	c	f									
1.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
2.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
3.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
4.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
5.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
6.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
7.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
8.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
9.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
10.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
11.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
12.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
13.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
14.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c
15.																															
	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	s	p/r	d	t	e	p/r	d	t	e	t	c

HEALTH DATA TRACKING INSTRUMENT

PART C

HEAD START CENTER _____

ADDRESS _____

YEAR _____ CLASS _____ SHEET _____ OF _____

- s = Screening
- p/r = Problem Referral
- d = Diagnosis
- t = Treatment
- e = Exam
- c = Dental Cleaning
- f = Dental Fluoride
- i = Immunization

- = Procedure or service not performed.
- = Procedure or service performed, follow-up (re-testing, referral, or treatment) needed.
- = Procedure or service begun.
- = Procedure or service completed.

ID. No.	IMMUNIZATIONS						FUTURE CARE	
	DPT	Polio	Measles	Rubella	Mumps		Medical	Dental
1.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
2.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
3.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
4.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
5.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
6.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
7.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
8.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
9.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
10.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
11.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
12.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
13.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
14.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		
15.	Latest _____ Next _____ s i	Latest _____ Next _____ s i	s i	s i	s i	s i		

HEALTH DATA TRACKING INSTRUMENT

PART D

ADDITIONAL CHILD-SPECIFIC INFORMATION
(Include any other information about health status that will help with case management.)

HEAD START CENTER _____
ADDRESS _____
YEAR _____ CLASS _____ SHEET _____ OF _____

ID. No.	TEST RESULTS (Screening, blood pressure, Hct., Hgb.)	OTHER IMPORTANT INFORMATION (Critical dates, atypical/abnormal findings, allergies, nutrition deficiencies, recommendations.)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		