

Date _____

Dear Health Care Professional:

According to **(FEDERAL PERFORMANCE STANDARD: 45 CFR 1304.20(a) (1) (ii) & (A)) and State ECEAP Performance Standard D-9:**

Head Start/Early Head Start Federal and State ECEAP programs are required to obtain from a health care professional a determination as to whether a child is up-to-date on a schedule of age appropriate preventive and primary health care. The schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate. This exam must include immunization recommendations issued by the Centers for Disease Control and Prevention.

Head Start/ECEAP/EHS follows the law for immunizations required for enrollment in Child Care (WAC 388-295-7020).

The Washington EPSDT Periodicity Schedule listed below is the resource we use to assist families in keeping their children up-to-date with well-child care.

To comply with the performance standard requirements we need the health-care provider to provide information requested on the back of this letter, including: immunizations administered and a complete copy of the Well-Child Exam, **parent authorization is included with this request and valid for the current school year as indicated on the back of this form.**

Thank you for taking the time to complete the information and returning the form to the program in a timely manner. Program guidelines require that we keep the information in a confidential child file. If you have any questions please do not hesitate to call.

Sincerely,

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HS/EHS Health Specialist
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Washington EPSDT Periodicity Schedule (as of July 1, 2006)

Age ⁵	Prenatal ¹	Newborn ²	2-4d ³	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 y	4 y	5 y
History															
Initial/Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Measurements															
Height and weight		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Head Circumference		X	X	X	X	X	X	X	X	X	X	X			
Blood Pressure													X	X	X
Sensory Screening															
Vision		S	S	S	S	S	S	S	S	S	S	S	S	O ⁶	O
Hearing		O	S	S	S	S	S	S	S	S	S	S	S	O	O
Developmental/ Behavioral Assess.⁸		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Examination⁹	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Procedures-General¹⁰															
Hereditary/Metabolic Screening¹¹		←	X	→											
Immunization¹²		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin¹³								X	→	R					→
Urinalysis															X
Procedures-Patients at Risk															
Tuberculin Test¹⁵										R	R	R	R	R	R
Cholesterol Screening¹⁶												R	R	R	R
Anticipatory Guidance¹⁷	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Injury Prevention¹⁸	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Violence Prevention¹⁹	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Sleep Positioning Counseling²⁰	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Counseling²¹	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental Referral²²									←					X	

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. These guidelines represent a consensus by the Committee on Practice and Ambulatory Medicine in consultation with national committees and sections of the American Academy of Pediatrics. The Committee emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

KEY:
x = to be performed
S = subjective, by history
O = objective, by a standard testing method
R = to be performed for patients at risk
← x → = subjective, by history

PARENT AUTHORIZATION AND WELL-CHILD EXAMINATION RECORD

PARENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Head Start/ECEAP/EHS and my child's primary care provider,

(provider name) _____

to receive and disclose information regarding current well-child exams, immunizations, lab work, referral, follow-up and/or treatment recommendations regarding:

Child's name _____ Birth date _____

Parent/legal guardian (please print) _____

Parent's/guardian's signature _____ Date _____

**AUTHORIZATION IS VALID FOR CURRENT SCHOOL YEAR OF _____
PARENT/GUARDIAN MAY REVOKE THIS AUTHORIZATION AT ANYTIME IN WRITING.**

WELL-CHILD EXAMINATION INFORMATION

1. Is child up-to-date for **WA State EPSDT** well child care? Yes No

CURRENT EXAM DATE _____ **NEXT EXAM DUE** _____

2. **Immunizations** given (or attach copy of immunization record) _____

3. Complete copy of current EPSDT Well-Child Exam included: Yes No

Treatment, Referral, Follow-up needed? Yes No If **Yes**, please explain:

The program would be glad to assist and support the treatment plan, referral or follow-up needed. Please explain:

RETURN THIS FORM TO:

Signature of provider (required)

Name of health care provider (please print)

Provider's phone