Palmdale School District
Launching a lifetime of learning

Early Childhood Education Program
975 East Ave P-8
Palmdale, CA 93550
(661)273-4710
(661)273-5139 Fax
www.palmdalesd.org

PRE-APPLICATION

Applicant's Name:(Child or Pregnant mother applying for services)	**DOB:**	**Gender:** __Male __Female

Name of Parent/Guardian A:	**DOB:**	**Gender:** __ Male __ Female
Relationship to Applicant: ___ Natural Parent/Adopted/Step ___ Foster ___ Grandparent ___ Other _____	**Check all Languages Spoken:** __ English __ Spanish __ Other _____	

Name of Parent/Guardian B: *(Living in the household - Yes/No)*	**DOB:**	**Gender:** __ Male __ Female
Relationship to Applicant: ___ Natural Parent/Adopted/Step ___ Foster ___ Grandparent ___ Other _____	**Check all Languages Spoken:** __ English __ Spanish __ Other _____	

Applicant's Living Address: _____	**Phone:**	**Alternate Phone:**

List additional children in the home: (*Do not include applicant listed above*)		
Name(s):	DOB:	Relationship to Applicant:
1.		
2.		
3.		
4.		
5.		
6.		

Name of Emergency Contacts:	**Phone:**	**Relationship to Applicant:**
1.		
2.		

Do you receive any of the following: (*Circle all that apply*)
CalWorks, Foster/KinGap/Adoption Assistance, Supplemental Security Income (SSI), Alimony, Child Support, Disability, Financial Aid, Social Security Income, Unemployment, Section 8, WIC, CalFresh, Medical

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Please circle age at exam:

_____12mo _____15mo _____18mo

_____24mo _____3yr _____4yr

Please complete each area of this exam including:

1. Yearly TB Assessment
2. Lead Test (Required at age 1 & 2)
3. Yearly Hemoglobin results

Head Start/Early Head Start
Physical Exam & Screening Tests

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LAST NAME, FIRST NAME, MIDDLE INITIAL OF CHILD	MALE	FEMALE	DATE OF BIRTH	SITE:
NAME OF PARENT OR GUARDIAN				CLASSROOM NUMBER/HOME BASE

TO BE COMPLETED BY HEALTH CARE PROVIDER

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE

TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM

ADDRESS

EXAMINATION MUST SATISFY CHDP REQUIREMENTS FOR AGE APPROPRIATE PHYSICAL

HEIGHT	WEIGHT	HEAD
inches (%)	lbs/oz (%) BMI for age (	CIRCUMFERENCE

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Blood Pressure (age 3+)			Mouth/			Genitalia		
Skin			Teeth/			Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Hearing		
Nose			Abdomen			Vision		

Vision Acuity (Age 3+)		Right	Left	Both	Hearing (Age 3+)		Frequency	Right	Left Ear
Date of Test		20/	20/	20/	Date of Test		1000 Hz	dB	dB
							2000 Hz	dB	dB
Type of Test					Type of Test		3000 Hz	dB	dB
							4000 Hz	dB	dB

Laboratory - Tests & Results				PPD-TB SCREENING-IF TB RISK PRESENT SKIN TEST IS REQUIRED				
DATE OF TEST	HGB GMS		HCT %	TB RISK FACTORS PRESENT LISTING ON REVERSE SIDE OF THIS FORM	YES-SKIN TEST REQUIRED		NO	
DATE OF TEST	LEAD mcg/dl		DATE OF FOLLOW-UP APPOINTMENT FOR LABS	DATE GIVEN	RESULTS mm	NO SIGNIFICANCE	SIGNIFICANT	DATE READ
TREATMENT NEEDED	YES	NO		DATE OF CHEST X-RAY	NORMAL	ABNORMAL	RX DATE	

TB Assessment is required during each exam. See questions on the back of this form

DATE OR AGE OF NEXT ROUTINE PHYSICAL EXAM	DIAGNOSIS OR ABNORMAL FINDINGS	TREATMENT/RESTRICTIONS/RECOMMENDATIONS FOR SCHOOL
AGE		
DATE		
OTHER -EXPLAIN		

TO BE COMPLETED BY HEAD START STAFF

SIGNATURE OF STAFF COMPLETING REVIEW	POSITION	DATE

HEAD START FOLLOW-UP	REFERRED FOR FOLLOW-UP TO: Nutrition MH FCP Education Health Disabilities
	Date/Initials when received:

Site:
Classroom:

Please fill in each section of this form in order for the dental exam to be complete for our program.

Thank you

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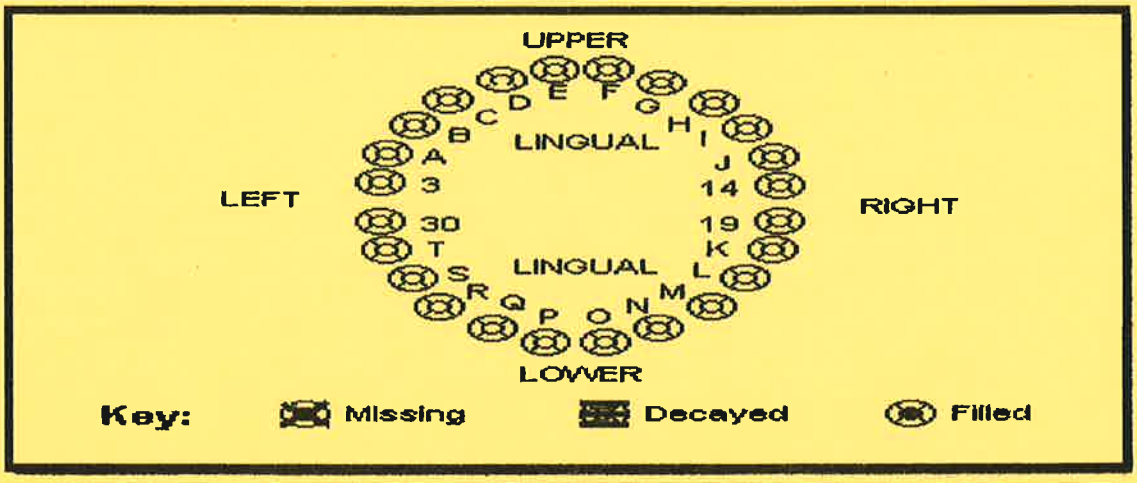
Early Childhood Education
Dental Exam

(Please fill out each section of this form)

Child's Name:	Date of Birth:	Gender: M F
Dental Insurance Type: □ Medi-cal □ Private □ None		



Date of Exam:	Services: □ Cleaning □ X-rays □ Fluoride □ Fillings □ Prophylaxis □ Follow-up Treatment □ Parent provided with education about oral health		
Priority Criteria:	□ Immediate Care □ Extensive Decay **Number of Cavities** _____	**□ No Cavities**	**□ Possible, Observing until:** _____
Dental Needs Identified:	□ Early Childhood Caries □ Baby Bottle Syndrome		
Results :	□ Routine recall visits in 6 months □ Treatment Initiated □Treatment Needed □ Treatment Completed □ Referred to Specialist		
Next Scheduled Appointment Date:			
Recommended Follow-up Care: *(please include treatment timeframe):*			
Dental Provider Signature or Stamp:		**Date:**	

FOR HEAD START STAFF ONLY

Signature of staff completing review:	**Position:**	**Date:**
□ Nutrition Referral		**Initial/Date received**

Date:_____
Rec'd By:_____
Staff Initiales

PALMDALE SCHOOL DISTRICT
EARLY CHILDHOOD EDUCATION PROGRAMS

975 E. Ave. P-8, Palmdale, California 93550
(661) 273-4710 FAX (661) 273-5139

COMMUNITY ASSESSMENT
2016-2017

ZIP CODE: _____ **HOME LANGUAGE:** _____ **ETHNICITY:**_____

RACE: ___ Asian ___ Black or African American ___ White ___ Other: _____

Total Number of Family in Household ____

Total Number of Children in Household: ages 0 - 3____ ages 4-5 _____

HOW DID YOU HEAR ABOUT THIS PROGRAM? Check all that apply.

___ School Flyer ___ Family Member ___ Community Event ___ Posted Flyer ___ Friend

___Spanish Newspaper Ad ___ English Newspaper Ad ___ Spanish Radio ___ English Radio ___ TV Ad

___ PSD Phone Message ___ Child previously enrolled in the program ___WIC

___ Child currently enrolled in the program Other (List) _____

WERE YOU REFERRED BY A COMMUNITY AGENCY (e.g., Doctor, Social Worker, etc)? **Yes___ No___**
If yes, list agency_____

IN YOUR OPINION, WHAT ARE <u>THE MOST IMPORTANT</u> COMMUNITY CONCERNS IN THE ANTELOPE VALLEY?
(If Applicable) Specify Concerns

_____

_____

Please check all that apply to your family:

TANF	
Homeless	
Supplemental Security Income	
WIC	
CalFresh (SNAP/Food Stamps)	
Less than High School Graduate	
High School Graduate/GED	
Associate Degree or some College	
Bachelors Degree or higher	

Single Female	
Single Male	
Married	
Employed - Both Parents	
Employed - One Parent	
Unemployed – Both Parents	
Unemployed – One Parent	
Foster Child	
Child with a disability	

MEDI-CAL PROVIDERS

OPTOMETRIST

Hull Eye Center
1739 West Ave J
Lancaster, Ca (661) 945-4502
(Does not accept Medical connected with HMO)

Nolan Ng
44407 N. 10th St W.
Lancaster, CA (661) 945-4508

AUDIOLOGY

Hearing Care Associates
4444 North 10th St. West
Lancaster, Ca (661) 942-7030

Lancaster Audiology
44241 North 15th St. West, Suite 204
Lancaster, Ca (661) 948-7377

Olive View Medical Center
14445 Olive View Drive
Sylmar, Ca (818) 364-3141
Will Need PM 160 + PM 161

DENTAL

American Dental
300 East Palmdale Blvd.
Palmdale, Ca
(661) 272-9000

Antelope Valley Dental Group
1037 E. Palmdale Blvd. Ste 203
Palmdale, Ca
(661) 272-9181

Family Dental Care
44558 10th St. West
Lancaster, Ca
(661) 723-1111

Hi-Desert Dental Center
2205 E. Palmdale Blvd.
Palmdale, Ca
(661) 273-13333
Lancaster Office
1745 W.Ave K Ste C
Lancaster, Ca
(661) 723-5400

Palmdale Dental
247 Palmdale Blvd
Suite B
Palmdale, Ca
(661) 266-0300

Posada Dental
849 W. Palmdale Blvd.
Palmdale, Ca
(661) 538-9300

Premier Dental Care
3002 E. Palmdale Blvd.
Suite 22
Palmdale, CA 93550
(661) 273-6565
Lancaster Office
43845 10th St. W
Suite # 1A
Lancaster, CA 93534
(661) 948-9646

Smile Dental Group
2508 E. Palmdale Blvd.
Palmdale, Ca
(661) 947-6453

Western Dental
510 W. Ave P
Palmdale, Ca
(661) 273-9000
Lancaster Office

Western Dental
44407 Challenger Way
Lancaster, Ca
(661) 341-3100

IMMUNIZATIONS/VACUNAS

Health Department/
Departamento de Salud
335 B East Ave K-6 Lancaster, Ca (661) 723-4526
FREE Immunizations for students with Medi-cal or government insurance. Children without insurance can receive unlimited at a cost of $15.00 (including Mantoux TB)
Monday thru Friday
7:30 a.m. - 10:30 a.m. and 12:00 p.m.- 3:00 p.m.
FREE CHEST X-RAYS with proof of positive TB testing

Vacunas gratis para los estudiantes con Medi-Cal o seguro del gobierno. Los niños sin seguro pueden recibir inmunizaciones ilimitadas a un costo de $15.00
De lunes a viernes
7:30 a.m. - 10:30 a.m. y 12:00 p.m. - 3:30 p.m.
RADIOGRAFIAS SON GRATIS
Con documentación de prueva positiva

Care-A-Van
44733 North Date Ave. Lancaster, Ca 93534
(661) 942-2391
Immunizations are administered to low income (Free to Medi-Cal or eligible children) on the last Friday of each month from 8:30 a.m. to 12:30 p.m. with Immunization Record only.
Please call to confirm date.

Vacunas son administradas (gratis para Medi-Cal ó para niños de bajo recursos) el último Viernes de cada mes,
de 8:30 a.m. y 12:30 p.m. con la Tarjeta de Vacunas. Por favor de llamar para confirmar el dia de vacunas.

PROVIDER LIST
CHILD HEALTH DISABILITY PREVENTION
LOW INCOME/PHYSICALS AND IMMUNIZATIONS
CHDP PHYSICAL EXAMS ARE FREE FOR ELIGIBLE CHILDREN
BIRTH THROUGH 19 YEARS OF AGE

ASK FOR A FREE CHDP PHYSICAL

CARE-A-VAN
Please call (661) 942-2391 for Schedule of locations

You may call to schedule an appointment for any of the following health providers at their centralized appointment phone line:
(661) 942-2391

LAKE L.A. COMMUNITY CLINIC
16921 East Avenue O, Space G
Palmdale
(661) 945-8205

SOUTH VALLEY HEALTH CENTER
38350 40TH Street East #100
PALMDALE
(661) 225-3050

PALMDALE PEDIATRIC CENTER
2271 E. Palmdale Blvd. E1
Palmdale
(661) 538-9922

HIGH DESERT REGIONAL HEALTH SYSTEM
335 E. Avenue I
LANCASTER
661-471-4000

ANTELOPE VALLEY COMMUNITY CLINIC-PALMDALE
2151 E. Palmdale Blvd.
Palmdale (661) 942-2391

BARTZ-ALTADONNA COMMUNITY HEALTH CARE
43322 GINGHAM AVE SUITE 105
LANCASTER (661) *945-8205*

CHDP DENTAL PROVIDERS

RICHARD ROTHSTEIN, RICHARD ROJAS, DDS
1154 EAST PALMDALE BLVD.
PALMDALE *(661) 947-2135*

YURI GEYLIKMAN, ORTHODONTICS
2205 E. PALMDALE BLVD
PALMDALE (661) 273-1333

ASK FOR A FREE CHDP DENTAL EXAM

16/17 KD