



Thank you for your interest in the Head Start / Early Head Start Program. Our program offers part day and full day preschool and family services in various locations throughout Santa Clara and San Benito Counties.

To qualify for our services your child must be age eligible AND your family must either be income or categorically eligible.

**ELIGIBILITY REQUIREMENTS**

**Age Eligibility:** For Head Start - Your child must turn 3 yrs old AND must not turn 5 yrs old by December 2<sup>nd</sup>  
 For Early Head Start – Your child must be at least 18 months and not yet 3 yrs. old

**Income Eligibility:** Your family is income eligible if your income meets the 2012 Federal Income Guidelines listed below:

SIZE OF FAMILY UNIT	GROSS ANNUAL INCOME	SIZE OF FAMILY UNIT	GROSS ANNUAL INCOME
1	\$ 11,170	5	\$ 27,010
2	\$ 15,130	6	\$ 30,970
3	\$ 19,090	7	\$ 34,930
4	\$ 23,050	8	\$ 38,890

*For families/households with more than 8 members, add \$3,960 for each additional person.*

**Categorical Eligibility:** Your family is eligible if you are in any of the following categories

- The child to be enrolled is in foster care
- The family is receiving benefits or services through the CalWORKs Program
- A family member living with and supported by you is receiving Supplemental Security Income benefits (SSI)
- The family is homeless

**Children with disabilities:** Income eligibility requirements for Head Start may be waived (until program has reached 10% enrollment of children with special needs) if your child has a current Individualized Education Program (IEP), or for Early Head Start if your child has a current Individualized Family Service Plan (IFSP).

**REQUIRED DOCUMENTS**

Your application must be complete and include copies of the following documents (**documents will not be returned**):

- **Birth Certificate**
- **Immunization Records**
- **TB Assessment and/or TB Test Results**
- **Income Verification** – Documentation must reflect your current economic status and must include all sources of income received by the child’s parents or guardians such as:
 

<ul style="list-style-type: none"> <li>✓ Current pay stubs showing two (2) months of income</li> <li>✓ Completed “Employer Income Verification” form showing hours worked and pay rate (only if unable to provide pay stubs)</li> <li>✓ Latest Income Tax Return or W-2 (if seasonally employed, self-employed, or if unable to provide pay stubs; must reflect current economic status)</li> </ul>	<ul style="list-style-type: none"> <li>✓ Unemployment Income</li> <li>✓ Worker’s Compensation</li> <li>✓ Child Support</li> <li>✓ Disability Income</li> </ul>
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- **Proof of Legal Custody** (if child is in foster care)
- **Notice of Action** (if receiving CalWORKs)
- **Proof of Supplemental Security Income** (if applicable)
- **Homelessness Verification** (if applicable and available)
- **Current IEP** (Head Start) **or IFSP** (Early Head Start) (if applicable)
- **Full Time Employment or School/Training Verification** (if you are requesting full day services)

**SUBMITTING YOUR APPLICATION**

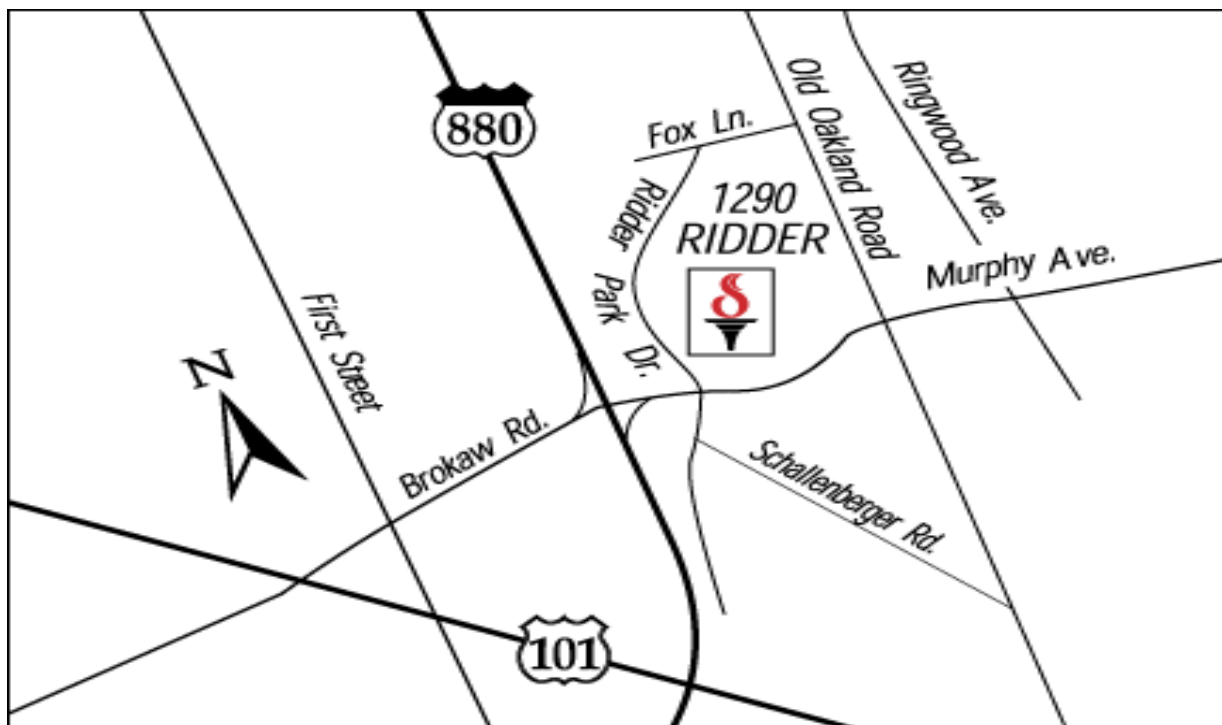
Once you have completed the application, you may submit your materials in one of the following ways:

- ✓ Call the office to ask for directions to the center nearest you
- ✓ Deliver in person or Mail to: Head Start Program, 1290 Ridder Park Drive, MC 225, San Jose, CA 95131-2304

**You will be contacted by mail once your application has been processed.**

If you have any questions, require assistance or need clarification completing this application, please call (408) 453-6900 or (800) 820-8182, Monday through Friday, 8:00 a.m. to 5:00 p.m.

# SCCOE RIDDER PARK MAP



The Santa Clara County Office of Education is located at 1290 Ridder Park Drive, San Jose, CA 95131-2304, just off Highway 880 at the corner of Brokaw Road and Ridder Park Drive.

There are several routes you may take to reach our office.

**If you are coming from Sunnyvale:** Take Highway 101 (south to San Jose) to the First Street/Brokaw Road exit. Stay in the far left lane and turn left onto Brokaw. Continue east on Brokaw for 1.3 miles, then turn left onto Ridder Park Drive. Take the first right into the County Office parking lot.

**If you are coming from North San Jose:** Take Highway 880 (south towards San Jose) to the Brokaw Road exit; stay in the left lane and turn left onto Brokaw Road. Continue east on Brokaw (through one more stoplight), move into the left turn lane and take a left onto Ridder Park Drive. Take the first right into the County Office parking lot.

**If you are coming from San Jose or South County:** Take Highway 101 (north to San Francisco); exit at Highway 880 North (towards Oakland) and in about one mile exit at the Brokaw Road. Turn right (east) onto Brokaw Road; move into the left lane. Turn left onto Ridder Park Drive. Take the first right into the County Office parking lot.

- Or -

Take Highway 880 North to the Brokaw Road exit. Turn right (east) onto Brokaw Road; move into the left lane. Turn left onto Ridder Park Drive. Take the first right into the County Office parking lot.

# HEAD START / EARLY HEAD START ENROLLMENT APPLICATION

CPID # \_\_\_\_\_

**PLEASE PRINT LEGIBLY USING BLACK OR BLUE INK ONLY**

## Survey

**How did you hear about the Head Start Program?**

Friend or Family    Community Agency    Community Event    Print Advertisement    Internet    Head Start Open House    Other \_\_\_\_\_

**Where did you get this application from?**

Friend or Family    Community Agency    Community Event    Head Start Website    Head Start Open House    Head Start Center  
 Head Start Main Office   [ In person    Via US Mail]    Other \_\_\_\_\_

## Child (Applicant)

First Name	Last Name	Middle	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/American Indian/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> Other:			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Does the child have a current IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please also complete the Disabilities questions on page 4				
I would like to apply for: <input type="checkbox"/> Full Day* <input type="checkbox"/> AM Session <input type="checkbox"/> PM Session <input type="checkbox"/> No Preference <small>*Note: To be eligible for full day both parents/guardians must be working full time (30+ hrs/wk or in school full time (12+ units)</small>				
In what language would you like to receive written information? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese				

## Family Information

Head of Household's Name			Relationship to Child	
Mother/Guardian's Name	Birth Date / /	Father/Guardian's Name	Birth Date / /	
Living Address		City/ Zip		<input type="checkbox"/> <b>Family is currently homeless</b>
Mailing Address (if different)		City/ Zip		
Home Phone <input type="checkbox"/> Primary phone	Cell Phone <input type="checkbox"/> Primary Phone	Work Phone <input type="checkbox"/> Primary Phone		
Mother/Guardian's Email Address <input type="checkbox"/> Primary		Father/Guardian's Email Address <input type="checkbox"/> Primary		
Parents/Guardians in the Home <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents	Name of Person Having Legal Custody of the Child		Is the child in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the child living with a relative or friend due to incarceration or abandonment? (excluding foster children) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Primary Language Spoken at Home <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____				
Do you or a family member living with and supported by you receive Supplemental Security Income benefits (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
At least, one parent/guardian is an active member of the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Does the child (applicant) have a sibling with a current IEP or IFSP? <input type="checkbox"/> Yes <input type="checkbox"/> No				

**List all other family members living in the household for whom you are responsible for the care and welfare of and are NOT listed above:**

First Name	Last Name	Birth Date	Is this person related to the child's parent(s)?	Is this person supported by the parent'(s) income?
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Total number of people living in the household (including you) for whom you provide financial support**

Other family members or friends we can contact in case we are unable to reach you

Name	Phone	Relationship
Name	Phone	Relationship

Laserfiche / Child's Binder Enrollment Section









**Authorization to Release Records**  
COMPLETE AND RETURN THIS FORM

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

I hereby authorize the release of the following records to Santa Clara County Office of Education, Early Learning Services Department Head Start Program:

**Physical examination, immunizations records (including a Tuberculosis Skin Test), dental examination and treatment plan, all assessment or diagnostic reports related to my child's health and development, and Individualized Educational Program (IEP) and/or Individualized Family Service Plan (IFSP) from school districts or other agencies.**

All release of information about my child will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Private Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2004; and Head Start Performance Standards (1301, 1304, 1305, and 1308).

I understand this information is strictly confidential and will be used to provide necessary services and to permit statistical reporting on the results of screenings. This authorization shall be valid for one year from date it is signed.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

**Authorization to Share Records**  
COMPLETE AND RETURN THIS FORM

**Child's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Parent/Guardian's Name** \_\_\_\_\_

The Santa Clara County Office of Education Head Start / Early Head Start Program has established partnerships with other child care agencies to be able to provide quality child care and family services to a larger number of children and families. If you allow us to share your enrollment application and pertinent information with our child care partners it could help us to find an opening for your child sooner. Children and families served by our child care partners receive all of the same benefits of a high quality Head Start or Early Head Start experience as is available in our directly operated classrooms.

If you consent to this release you may be contacted by one of our child care partner agencies about enrollment opportunities in their program.

**Child Care Partners of the SCCOE Head Start / Early Head Start Program:**

- East Side Union High School District Child Development Program (Early Head Start)
- Community Child Care Council of Santa Clara County, Inc. (4C's; Early Head Start)
- Kidango, Inc.
- Mountain View Whisman School District
- State Preschool Programs
- SJB Child Development Center

All release of information will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Privacy Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2004; and Head Start Performance Standards (1301, 1304, 1305, and 1308).

- Yes, I authorize the release of my child's enrollment application and pertinent information to be sent to child care partner agencies to facilitate the enrollment of my child into a preschool program.
- No, I do not authorize the release of my child's enrollment application and pertinent information to be sent to child care partner agencies.

\_\_\_\_\_  
**Parent/Guardian's Signature**

\_\_\_\_\_  
**Date**

**Dental Examination**

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Center Name \_\_\_\_\_ Enrollment Date \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION / AUTORIZACIÓN PARA REVELAR INFORMACIÓN / LỜI CHO PHÉP QUẢNG BÁ CHI TIẾT**

I authorize release of dental information contained in this report to the Head Start Program  
Yo autorizo a que la información dental que aparece en este reporte sea revelada al Programa Head Start  
Tôi cho phép quảng bá các chi tiết y khoa ở trên bản báo cáo này đến Chương Trình Head Start.

Parent/Guardian's Signature / Firma Del Padre-Tutor / Phụ Huynh Hoặc Giám Hộ Ký Tên \_\_\_\_\_

Date / Fecha / Ngày \_\_\_\_\_

Dear Dental Provider:

Please fill out this form completely, sign, and return to the child's parent/guardian listed above. If the child requires more than a routine check-up, we will require information when the initial examination is done and when treatment has been completed\*. **Please note: when routine care is provided by a hygienist, Head Start guidelines require a dentist signature to ensure that care has been provided.**

Date of most recent dental examination \_\_\_\_\_

- Child received prophylaxis, OHI and fluoride application
- Child had x-rays taken
- Was child prescribed fluoride  Yes  No
- Decay  Yes  No
- Results**  Is treatment required at this time other than preventive care?  Yes  No
- Class I Prevention (sealant/fluoride/prophylaxis)
- Class II Moderate dental problems (cavities into dentin – less than 3 teeth)
- Class III Severe dental problems (more than 3teeth have cavities, cavities involving the pulp)
- Class IV Emergency dental treatment required (abscess/pain/rampant decay)
- Next appointment date for routine care \_\_\_\_\_

Dentist's office stamp/name, phone number, and address (required) \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*COMPLETE THIS SECTION ONLY IF TREATMENT OTHER THAN PREVENTATIVE CARE IS REQUIRED.**

**Summary of Treatment**

- Treatment completed  Yes  No Date \_\_\_\_\_
- Pulpal treatment
- Extraction of non-restorable teeth  Space maintainers
- Restoration of decayed teeth (fillings /crowns)
- Referred to specialist (Dentist name & specialty) \_\_\_\_\_
- Next appointment date for treatment \_\_\_\_\_
- Other \_\_\_\_\_

Dentist's Signature (\*\*treatment required ) \_\_\_\_\_

## CHDP DENTAL PROVIDERS

<p><b>Cyrus M. Akhbari</b>  <b>Pediatric Dentistry</b>            1201 Park Avenue, Suite 2            San Jose, CA 95126            (408) 971-9990            Spanish/Farsi/Vietnamese</p>	<p><b>Children's Dental Center</b>            1153 South King Road            San Jose, CA 95122            (408) 240-0250            Spanish/Vietnamese</p>	<p><b>Indian Health Center Dental Department</b>            1333 Meridian Avenue            San Jose, CA 95125            (408) 445-3400 ext. 230 or 280            Spanish            Saturdays by appointment only</p>
<p><b>Comprecare Dental</b>            3030 Alum Rock Avenue            San Jose, CA 95127            (408) 254-5185            Spanish/Vietnamese            Open Monday through Saturday</p>	<p><b>Dental Image</b>  <b>Adrienne N. Lan Van</b>            2114 Senter Road, Suite 14            San Jose, CA 95112            (408) 298-8187            Spanish/Vietnamese</p>	<p><b>Daisy G. Ison</b>            2340 McKee Road, Suite 22            San Jose, CA 95116            (408) 272-8855            Spanish/Tagalog</p>
<p><b>Evergreen Dental Group</b>            3162 Newberry Avenue            San Jose, CA 95118            (408) 274-9600            Spanish</p>	<p><b>Tully Dental Center</b>            500 Tully Road            San Jose, CA 95111            (408) 808-6102            Spanish</p>	<p><b>Duong Chi Nguyen</b>            88 Tully Road, Suite 109            San Jose, CA 95111            (408) 298-1221            Vietnamese</p>
<p><b>Jackson Family Dental</b>            2324 Montpelier, Suite 3            San Jose, CA 95116            (408) 937-5950            Spanish/Farsi</p>	<p><b>Devinder S. Shoker</b>            1295 South Park Victoria Drive            Milpitas, CA 95035            (408) 945-0411            Spanish/Vietnamese/Hindi/Tagalog</p>	<p><b>Lucky Dental</b>            2003 Story Road, Suite 800            San Jose, CA 95122            (408) 928-6000            Spanish/Chinese</p>
<p><b>San Jose Dental Surgery Center</b>  <b>Children's Dental Clinic</b>            1998 Alum Rock Avenue            San Jose, CA 95116            (408) 240-9000            Spanish/Vietnamese</p>	<p><b>Maria Villar</b>  <b>Willow Dental Health Center</b>            283 Willow Street            San Jose, CA 95110            (408) 298-6411            Spanish</p>	<p><b>Son A. Tran</b>            260 Aborn Road, Suite 150            San Jose, CA 95121            (408) 239-0816            Vietnamese</p>
<p><b>Asadi H</b>            3535 Ross Avenue, Suite 105            San Jose, CA 95124            (408) 267-5600            Spanish/Farsi</p>	<p><b>Western Dental Center</b>            Accepts all types of Medical and children as young as 1 year old            Call to make an appointment at            1(800) 466-5555 ext 3304            Spanish</p>	<p><b>City Dental Center</b>            7671 Monterey Road, Suite C            Gilroy, CA 95020            (408) 842-5000            Spanish/Farsi</p>
<p><b>South Valley Dental Clinic</b>            7475 Camino Arroyo Circle            Gilroy, CA 95020            (888) 334-1000            Spanish</p>	<p><b>South County Dental Center</b>  <b>Gardner Health</b>            7526 Monterey Street            Gilroy, CA 95020            (408) 846-6473            Spanish            Open Monday through Saturday</p>	<p><b>San Benito Health Foundation</b>  <b>Dental Department</b>            351 Felibe Drive            Hollister, CA 95023            (831) 637-1897</p>
<p><b>Virginia Caverro, DSS</b>            345 5<sup>th</sup> Street, Suite 2            Hollister, CA 95023            (831) 636-6510</p>	<p><b>Santa Ana Dental</b>            4 East Street            Hollister, CA 95023-4004            (831) 634-0411</p>	<p><b>Terry Slaughter, DDS</b>            901 Sunset Drive, Suite 5            Hollister, CA 95023            (831) 636-8484</p>

**Your child could be eligible for free dental exam.**

**Call the numbers below for information on free or low cost children's health insurance programs:**

<b>Children's Health Initiative</b>	1 (888) 244-5222
<b>Child Health &amp; Disability Prevention Program</b>	(408) 494-7410
<b>Medi-Cal Eligibility</b>	(408) 271-5600
<b>Santa Clara Family Health Foundation</b>	1 (877) 680-4555

**CHILD HEALTH ASSESSMENT REPORT – CONFIDENTIAL**

**Medi-Cal / CHDP / Medical Providers:** Please complete screening and return to parent/guardian in the Head Start / Early Head Start Program.

Child's Last Name:	First name	Initial	Sex M    F	Birth Date		
				Month	Day	Year

**SECTION TO BE COMPLETED BY PARENT OR GUARDIAN**

<b>AUTHORIZATION FOR RELEASE OF INFORMATION / AUTORIZACIÓN PARA REVELAR INFORMACIÓN / LỜI CHO PHÉP QUẢNG BÁ CHI TIẾT</b> I authorize release of medical information contained in this report to the Head Start Program / Yo autorizo que la información médica que aparece en este informe sea revelada al Programa Head Start / Tôi cho phép quảng bá các chi tiết y khoa ở trên bản báo cáo này đến Chương Trình Head Start.	
SIGNATURE OF PARENT OR GUARDIAN / FIRMA DEL PADRE O TUTOR / PHỤ HUYNH HOẶC GIÁM HỘ KÝ TÊN	DATE / FECHA / NGÀY

**HEALTH CARE PROVIDER MUST COMPLETE ALL ITEMS BELOW**

The Santa Clara County Office of Education administers a Head Start Program which is federally funded. Federal regulations require that a health professional make a determination as to whether a child is up to date on a schedule of age appropriate health assessments and screenings.

Date of Service	Month	Day	Year	Child's Age	Years	Months	Allergies		
<b>Height / Length Required</b> (Inches)		<b>Weight Required</b> (Pounds)		<b>BMI Percentile</b> (2, 3, 4, 5 yrs. old only)  *Over weight? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method of treatment _____		<b>Blood Pressure</b> (3, 4, 5 yrs. old only)  /  BP Elevated _____		<b>Vision Chart Exam</b> OD _____ OS _____ OU _____  Corrected / Uncorrected	<b>Head Circumference</b>  (Inches) _____
<b>Please indicate outcome for each screening procedure</b> (Refer to Periodicity Schedule on reverse of form)				No Problem Suspected ✓	Problem Suspected ✓	<b>* If a problem is diagnosed at this visit, please enter diagnosis, treatment plan, and special care instructions or restrictions in this area.</b>			
<b>History and Physical Exam</b>									
<b>Dental Assessment / Referral</b>									
<b>Develop / Behavioral Surveillance</b>									
<b>Anticipatory Guidance</b>									
<b>Psychosocial Assessment</b>									
<b>Tobacco Assessment</b>									
<b>Hemoglobin or Hematocrit</b> Starting at 9-12 months, then annually at 2, 3, 4, and 5 yrs. old		<b>Hgb Values</b>  Date	<b>Hct Values</b>  Date	<b>* Anemia Diagnosis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method of treatment _____			<b>Nutrition Assessment</b> Has child been diagnosed with food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____		
<b>Blood Lead Level (BLL)</b> required at 12 and 24 months; Test at 24-72 months, if not tested previously		<b>BLL Value</b>	<b>Date</b>	<b>* Need status of BLL Value</b>			<b>If tests were not done, please explain why?</b>		
		<input type="checkbox"/> Blood Lead Risk Assessment (Please check box)							
<input type="checkbox"/> 0 – 35 months old – Sensory Screening Hearing Clinical Assessment									
<input type="checkbox"/> 0 – 35 months old – Sensory Screening Vision Clinical Observation									
<input type="checkbox"/> 3 – 5 yrs. old – Hearing Screening			<input type="checkbox"/> Pass		<input type="checkbox"/> Unable/Uncooperative		<input type="checkbox"/> Re-Screen		
<input type="checkbox"/> 3 – 5 yrs. old – Vision Screening			<input type="checkbox"/> Pass		<input type="checkbox"/> Unable/Uncooperative		<input type="checkbox"/> Re-Screen		
<b>Tuberculin Verbal Risk Assessment</b> Required 0-60 months		<input type="checkbox"/> Verbal Risk Assessment Completed (Please check box)							
<b>* Is TB Test required at this time?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>* Complete this section only if TB Test is required</b> Date Given		Date Read		Results in millimeters _____		Date X-Rays Taken _____	
						<input type="checkbox"/> Negative <input type="checkbox"/> Positive		X-Rays Results _____	
<b>Child's needs Immunizations?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No									
<b>Immunizations given today</b> Date _____		Polio (OPV or IPV) _____		DTP _____		MMR _____		HIB _____	
		Hepatitis B _____		Varicella _____		PCV _____		Other _____	
<b>Provider of Service (Please include name, address, and telephone number)</b>					<b>Referred to</b>			<b>Telephone Number</b>	
<b>Provider's Signature</b>								<b>Date</b>	

## HEAD START / EARLY HEAD START PERIODICITY SCREENING GUIDELINES

Note: These guidelines follow the recommendations of the Centers for Disease Control and Prevention (CDC) and the Child Health and Disabilities Prevention (CHDP) Programs

### PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS

Screening Requirements	Age of Person Being Screened										
	Under 1 mo.	1-2 Mos.	4 Mos.	6 Mos.	9 Mos.	12 Mos.	15 Mos.	18 Mos.	2 yrs.	3 yrs.	4-5 yrs.
Interval Until Next Exam	1 mo.	2 mos.	2 mos.	2 mos.	3 mos.	3 mos.	3 mos.	6 mos.	1 yr.	1 yr.	2 yrs.
<b>History &amp; Physical Examination</b>	•	•	•	•	•	•	•	•	•	•	•
Dental Assessment	•	•	•	•	•	•	•	•	•	•	•
Nutritional Assessment	•	•	•	•	•	•	•	•	•	•	•
Developmental / Behavioral	•	•	•	•	•	•	•	•	•	•	•
Psychosocial Assessment	•	•	•	•	•	•	•	•	•	•	•
Tobacco Assessment	•	•	•	•	•	•	•	•	•	•	•
<b>Measurements</b>											
Head Circumference	•	•	•	•	•	•	•	•			
Height / Length and Weight	•	•	•	•	•	•	•	•	•	•	•
BMI Percentile									•	•	•
Blood Pressure										•	•
<b>Sensory Screening</b>											
Visual Acuity Test (Snellen) <sup>2</sup>										•	•
Clinical Observation	•	•	•	•	•	•	•	•	•	•	•
Audiometric <sup>2</sup>										•	•
Non-Audiometric	•	•	•	•	•	•	•	•	•	•	•
<b>Procedures / Tests</b>											
Tuberculin Test if at Risk											
TB Exposure Risk Assessment		•	•	•	•	•	•	•	•	•	•
Hematocrit or Hemoglobin				*	• →		*	*	•	•	•
Blood Lead Risk Assessment				•	•	•	•	•	•	•	•
Blood Lead Test						•			•	X →	
Anticipatory Guidance	•	•	•	•	•	•	•	•	•	•	•
<b>Other Laboratory Tests</b>											
Urine Dipstick or Urinalysis	To be done when health history and/or physical examination warrants										
VDRL, RPR, or ART	To be done when health history and/or physical examination warrants										
Gonorrhea Test	To be done when health history and/or physical examination warrants										
Chlamydia Test	To be done when health history and/or physical examination warrants										
Papanicolaou (Pap) Smear	To be done when health history and/or physical examination warrants										
Sickle Cell	To be done when health history and/or physical examination warrants										
Ova and Parasites	To be done when health history and/or physical examination warrants										
<b>Immunizations</b>	<b>Administer as necessary to make status current</b>										

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

1. Snellen testing and Audiometric testing should start at age 3 if possible. Clinical observation and non-audiometric testing may be substituted if child is uncooperative.

### Pediatric Primary Care Providers

#### Valley Health Center Bascom

750 South Bascom Avenue  
San Jose, CA 95128  
1 (888) 334-1000

#### Valley Health Center Tully

500 Tully Road  
San Jose, CA 95111  
1 (888) 334-1000

#### Valley Health Center East Valley

1993 McKee Road  
San Jose, CA 95116  
1 (888) 334-1000

#### Valley Health Center Silver Creek

1620 East Capitol Expressway  
San Jose, CA 95121  
1 (888) 334-1000

#### Valley Health Center Fair Oaks

660 South Fair Oaks Avenue  
Sunnyvale, CA 94086  
1 (888) 334-1000

#### Valley Health Center Gilroy

7475 Camino Arroyo Circle  
Gilroy, CA 95020  
(888) 334-1000  
1 (888) 334-1000

#### Community Clinics / Health Centers:

##### Franklin-McKinley Neighborhood Clinic

645 Wool Creek Drive  
San Jose, CA 95112  
(408) 283-6051

##### Gilroy Neighborhood Health Clinic

7861 Murray Avenue  
Gilroy, CA 95020  
(408) 842-1017

##### San Jose High Neighborhood Clinic

1149 East Julian Street, Building H  
San Jose, CA 95116  
(408) 535-6001

#### Indian Health Center

1333 Meridian Avenue  
San Jose, CA 95125  
(408) 445-3400

#### San Jose Foothill Family Community Clinic

2880 Story Road  
San Jose, CA 95127  
(408) 729-4282

#### Washington Neighborhood Health Clinic

100 Oak Street  
San Jose, CA 95110  
(408) 295-0980

#### Gardner Family Health Network:

##### CompreCare Health Center

3030 Alum Rock Avenue  
San Jose, CA 95127  
(408) 259-8400

##### Gardner Health Center

195 East Virginia Street  
San Jose, CA 95112  
(408) 918-5500

##### St. James Health Center

55 East Julian Street  
San Jose, CA 95112  
(408) 918-2600

##### Gardner South County Health Center

7526 Monterey Street  
Gilroy, CA 95020  
(408) 848-9400

#### Mayview Community Health Centers:

##### Columbia Neighborhood Center

785 Morse Avenue  
Sunnyvale, CA 94085  
(408) 523-8150

#### Mayview Community Health Center at Mountain View

100 North Moffett Blvd., Suite 101  
Mt. View, CA 94043  
(650) 965-3323

#### Planned Parenthood:

##### Planned Parenthood, Blossom Hill

5440 Thornwood Drive, Suite G  
San Jose, CA 95123  
(408) 281-9777

##### Planned Parenthood, San Jose

1691 The Alameda  
San Jose, CA 95126  
(408) 287-7526

##### Mar Monte Community Clinic

2470 Alvin Avenue, Suite 80  
San Jose, CA 95121  
(408) 274-7100

##### Planned Parenthood, Sunnyvale

604 East Evelyn Avenue  
Sunnyvale, CA 94086  
(408) 739-5151

##### Planned Parenthood, Mt View

225 San Antonio Road  
Mt. View, CA 94040  
(650) 948-0807

### San Benito County

#### Hazel Hawkins Community Health Clinic

930 Sunset Drive, Building 3  
Hollister, CA 95023  
(831) 636-2664

#### Office hours

Mon - Fri – 8:00 am – 8:00 pm  
Saturday - 8:15 am – 5:00 pm  
Sunday – 8:15 am – 12:00 noon

#### San Benito Health Foundation

351 Felice Drive  
Hollister, CA 95023  
(831) 637-5306

### ***YOUR CHILD COULD BE ELIGIBLE FOR A FREE HEALTH EXAM***

#### **Call the numbers below for information on free or low cost children's health insurance programs:**

Children's Health Initiative	1 (888) 244-5222
Child Health & Disability Prevention Program	(408) 494-7410
Medi-Cal Eligibility	(408) 271-5600
Santa Clara Family Health Foundation	1 (877) 680-4555