

CHILD/FAMILY SERVICES EXCLUSION NOTICE

Date _____

Child's Name _____

Service Options: ___ Center Based ___ Home Based ___ FCCH

Location _____

Teacher/Provider _____

Dear Parent or Guardian,

State and Federal regulations require children enrolled in the Head Start program to have:

- A. All immunizations current or up to date prior to enrollment
- B. A physical exam within 30 days of enrollment including a valid TB assessment/test

Our records show that your child is in need of:

- | | | | |
|--|----------------------------------|-------------------------------------|------------------------------|
| <input type="checkbox"/> Physical exam | <input type="checkbox"/> HGB/HCT | <input type="checkbox"/> TB | <input type="checkbox"/> DTP |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> Polio | <input type="checkbox"/> HIB | <input type="checkbox"/> MMR |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Hep A | <input type="checkbox"/> Lead Level | |

Therefore, effective _____, your child must be excluded from the program until written evidence is presented that the above has been obtained.

Please contact your health care provider for an appointment or your Head Start Health Staff if assistance is needed.

Your child will be readmitted to the program as soon as you present written evidence of the above requirements.

Nurse/Health Staff

Phone # _____

Parent Signature: _____ Date: _____