



CCFS Head Start & Early Head Start Program Agency Forms

Title of Form: Red Flag Form
Who Fills Out Form: Family Service Associate, Enrollment Clerks, Specialist
Goes To: White copy goes to Specialist referring to All other copies are to remain with the file and be sent to ERSEA for further distribution. The pink copy always remains with the file.
Due Date: At time enrollment application taken, or during health or ERSEA review.
Purpose: To help ensure adequate transition activities and assist staff preparation for children entering program with atypical needs
Important Notes: See attached Red Flag Criteria sheet for examples of conditions that would necessitate a Red Flag. This form is only to be used during pre-enrollment or application period, and does not in any way replace the CCFS agency Internal Referral form or process.
HEAD START PERFORMANCE STANDARDS REFERENCE NUMBER: Transition requirements

RED FLAG CRITERIA

Health

- a. Chronic Illness: Asthma, Eczema, Seizures, Sickle Cell Anemia, Cystic Fibrosis, Orthopedic concerns
 - i. Asthma: under current medical treatment for condition. Follow Up with Parent Asthma Assessment and protocol.
 - ii. Eczema: also request any special lotions, soaps to be used for child, and what if any triggers are present for child.
 - iii. Seizures: Date, Length, Last Occurrence. Follow up with Parent Seizure Assessment
- b. Child is being followed by a Health Service Provider for Occupational Therapy/ Physical Therapy. Example: Huntington Neonatal Clinic, California Children Services, Glendale Adventist Hospital. This can also be crossed with Disabilities.
- c. Acute Illness/Past: Heart condition(for which child is currently being monitored), Cancer
- d. Allergies: pet allergies, environmental
- e. Toileting issues as it relates to health concerns (chronic constipation, diarrhea)
- f. Frequent ear infections within the last 2 years.
- g. Medications: Epi-pen, Albuterol, Creams, Insulin
- h. Multiple Birth (Twins, etc)

2. Nutrition

- a. Chronic nutrition concerns: Diabetes, Inborn Error of Metabolism
- b. Diet restrictions: Kosher diet, no meat, no pork
- c. Food Allergies: i.e. peanuts, soy, or any noted food allergy
- d. Anemia: Hgb \leq 11.2, Hct \leq 34%
- e. Lead: $>10\mu\text{g}/\text{dl}$
- f. Weight Concerns: ($>95^{\text{th}}$ percentile, $< 5^{\text{th}}$ percentile); Failure to Thrive, or weight concern noted by medical doctor/nurse practitioner
- g. Child is being followed by a Nutrition Service Provided (feeding clinic, dietitian)

3. Disabilities

- a. Speech delay or impairment: suspected or diagnosed, or noted by medical doctor/nurse practitioner
 - i. **If diagnosed provide copy of IFSP/IEP**
- b. Premature birth: 32 weeks or earlier/7 months gestation or earlier
 - i. Inquire from parent if child received early intervention services. **Then obtain documentation.**
- c. Diagnosed or suspected (parental/health care provider) developmental delays
- d. Any child with an IFSP/IEP
- e. Children in the process of being assessed and has a referral.
- f. If the parent/s themselves have been diagnosed with a disability or special need.

4. Mental Health

- a. Restraining order (Attach any court documentation)
- b. Foster Child/Kinship (Attach any legal custody documents)
- c. Behavioral concerns (Suspected by parent(s) or identified)
- d. Parents Needs/Concerns (Counseling, marital, domestic violence, predispositions to Mental Illness)

5. Other

- a. Refusal for screenings
 - i. Nutrition, Behavioral, Referrals, Health Services/Screenings, Developmental screenings
- b. Refusal for enrollment in Link
- c. Refusal of immunizations (Medical/Religious/Philosophical Exemption)
- d. Change in status of health insurance (dropped insurance, change of status of enrollment)
- e. Other legal concerns

When in doubt, please seek assistance from the perspective specialist.

Center for Community & Family Services, Inc
Head Start / Early Head Start / PKFLP
Red Flag

Form to be completed for children applying to the program.

Program Year

Child's Name:	DOB:
Parent's Name:	Home Language:
Parent's Contact Information:	
Address:	
*Date Completed:	Staff Making Referral:
Title:	

Referring to: (Each service area checked, must get a copy of the referral.)

- | | |
|--|---|
| <input type="checkbox"/> Health _____
<input type="checkbox"/> Disabilities _____
<input type="checkbox"/> Mental Health _____
<input type="checkbox"/> Nutrition _____ | <input type="checkbox"/> Education _____
<input type="checkbox"/> Family Services _____
<input type="checkbox"/> Other: _____ |
|--|---|

Describe nature of concern/problem: (Attach additional paper as necessary)

List supporting documents attached:		Consent not given for:
<input type="checkbox"/> IEP/IFSP		<input type="checkbox"/> Developmental/behavioral Screen
<input type="checkbox"/> Court Documents		<input type="checkbox"/> Hearing Screening
<input type="checkbox"/> Medical Documents		<input type="checkbox"/> Vision Screening
<input type="checkbox"/> Assessments		<input type="checkbox"/> Immunizations
<input type="checkbox"/> Other (list)		<input type="checkbox"/> LINK participation
		<input type="checkbox"/> Photos

Date Received:	Specialist Signature:
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Specialist Instructions:

Child Plus Data Entry:

*Result:	*Description:	*Status:
Action Type: (circle)	Evaluation Follow-up Referral Treatment	
Scheduled Date:	Action Date:	Status:
Description:	Provider:	Provider Type:

Original - Forward to Specialist (additional copies as needed)

NCR - To stay with application