

ECELS EARLY CHILDHOOD EDUCATION ENCOUNTER FORM

Date Service Requested _____ Date of Service _____

Contact Person Name _____ ECE Program Name _____

Street Address _____

City _____ Zip code _____ County _____

Telephone (_____) _____ Email _____ @ _____

Technical Assistance (TA) consultation delivered to early childhood education (ECE) provider on-site phone email other

From the items below, **check, highlight or fill in** the appropriate response which best describes the TA provided during this encounter:
Specify **all** topics addressed during this encounter: (e.g. hand washing, lice, TB testing, lead, first aid training, etc.)

- Helped facility with compliance with state regulations and national standards (e.g. health record review)
- Linked ECE provider with other community resources
- Assist ECE provider with helping families obtain health insurance (CHIP, Medicaid)
- Addressed the environment of the ECE facility
- Addressed the performance of ECE staff in the facility
- Observed individual children to assess their needs (specify) _____
- Provided "hands-on" screening or examination services
- Developed health policies/procedures
- Helped interpret clinical information about children for ECE staff
- Addressed staff health issues
- Helped accommodate children or families with special health needs
- Facilitated linkage for families with a medical home to provide child health services
- Provided health education for: # _____ children # _____ staff # _____ parents / guardians
- Provided materials
- Referred ECE provider to ECELS
- Other (specify) _____

Check every category addressed during this encounter:

- Infectious Disease Health Promotion Other (specify) _____
 Injury Special Health Needs

Areas to Improve: (Use brief one-word descriptions or short phrases.)

Follow-up or additional resources needed:

Number of children enrolled in facility by age range: (Give specific number in each age group, do not give a range.)

Infants (0-12 months of age) _____ Toddlers (13-35 months of age) _____
 Preschool-age (3-5 years of age) _____ School-age _____

Number of caregivers / teachers employed in facility: _____ (Give specific number, do not give a range).

Estimated Total Time Required for Service: _____ # hours _____ # minutes

Health Consultant Signature _____ Email _____ Phone (_____) _____
Agency _____