HEARING SCREENING FORM

Child's name: ____________________________ Child's DOB: _________________

Center name: ____________________________ Class code: __________________

Tester name: ____________________________ Test date: _________________

HEARING WILL BE SCREENED AT 25 DB
FREQUENCIES

<table>
<thead>
<tr>
<th></th>
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<th>2000</th>
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<tbody>
<tr>
<td>RIGHT EAR</td>
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<td>LEFT EAR</td>
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</tr>
</tbody>
</table>

******* (ANY (–) INDICATES REQUIRED RECHECK) *******

✓ = Pass                  Testing Result: Pass     Recheck
- = Refer                (circle one)

HEARING RECHECK

Date: _________________________

Tester Name: __________________

FREQUENCIES

<table>
<thead>
<tr>
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</tr>
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<tbody>
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<td>RIGHT EAR</td>
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<td>LEFT EAR</td>
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</tr>
</tbody>
</table>

******* (ANY (–) INDICATES REQUIRED AuDx TESTING) *******

Testing Results: Pass     Refer
(circle one)

Please staple AuDx testing results in this area

*******FORM DEVELOPED UNDER THE GUIDANCE OF DR. DANIEL R. SCHUMAIER AND ASSOCIATES, AUDIOLOGIST*******
Upper East Tennessee Human Development Agency, Inc.
Head Start Program

Physician’s Instructions for Head Start Staff
to Administer Medication During Head Start Hours

Name of Child _____________________________________________________________

Date of Birth ____________________________________________________________

The above named child requires the following:

1. Type of Medication_______________________________________________________

2. Dosage_______________________________________________________________

3. Reason to be given______________________________________________________

4. Contraindications_______________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

5. Significant side effects that should be noted______________________________
   ___________________________________________________________________

6. Time period for which medication is to be given___________________________
   ___________________________________________________________________

7. Other instructions_______________________________________________________
   ___________________________________________________________________

Name of Physician_______________________________________________________
(Please Print)

Physician’s Address_______________________________________________________
(Please Print)

Physician’s Phone Number________________________________________________

Physician’s Signature_________________________________________________________________ Date __________
Upper East Tennessee Human Development Agency, Inc.
Head Start Program

Administering Medication Referral

_______________________                                                         _________________________
Center/County         Teacher

_______________________                                                         _________________________
Child’s Name                                                                                   Parent/Guardian

The above named child will be receiving medication while attending Head Start. The type of medicine/dosage to be given is ______________________________ and is to be administered __________________________ and __________________________________
(Type of Medicine)

(Teacher)                          (Teacher Assistant)
are requesting administering medication training for the above named child. We have received form 4.08A, “Physician’s Instructions for Head Start Staff to Administer Medication During Head Start Hours,” completed by the physician.

_____________________________
(Family Resource Specialist)

For Office Use Only

Date Received _____________________

Training Date for Staff ______________

Original to: Quality Assurance Staff

Compiled by David Sproles 8-5-97
Upper East Tennessee Human Development Agency, Inc.  
Head Start Program

Parental Permission for Administering Medication During Head Start Hours

Head Start Center: __________________________________________________________

I, ______________________________________, parent/guardian of ___________________  
(Print Name of Parent/Guardian)                                                  (Print Child’s Name)

hereby give my permission to the program staff to administer medication to my child.

Medication Type______________________________________________________________

Prescription#_________________________________________________________________

Dosage______________________________________________________________________

Time________________________________________________________________________

Date Medication is to be discontinued____________________________________________

Release and Waiver of Liability

The undersigned parent and/or legal guardian waive all claims for damages against Upper East Tennessee Human Development Agency (UETHDA) and its officers and employees for injury to our child’s person or property, including death and destruction, and resulting injuries and damages to us, that may arise from this activity. We release UETHDA and its officers and employees and agree to hold them harmless from and such liability. The undersigned parent or legal guardian further states that he or she has carefully read the foregoing release, knows the content thereof, and signs it as his or her own free act and deed. This agreement shall remain in force until we revoke it in writing.

______________________________________________    ____________________
Parent/Guardian’s Signature       Date

______________________________________________    ____________________
Parent/Guardian’s Signature       Date

We are requesting that both parents or legal guardians sign this permission form. If both parents or both legal guardians are unable to sign this permission form, please indicate the reason below:

I am the legal sole custodial parent or legal guardian of this child.  
(Legal documentation has been provided to the Head Start Program)

The other parent or legal guardian is a non-resident and is not able to be contacted or whereabouts are unknown
Upper East Tennessee Human Development Agency, Inc.
Head Start Program

Documentation of Training to Administer Medication

Date of Training____________________________  Center________________________

Child’s Name__________________________________________________________________

Type of Medication______________________________________________________________

The following Head Start Staff received training to administer medication:

1. Primary Head Start Staff Person______________________________________________

2. First Back-Up Head Start Staff Person_________________________________________

3. Second Back Up Head Start Staff Person (If Available) ___________________________

The training concerning administering medication was conducted by_______________________

Name (Please Print)________________________________________________________________

Title (Please Print)________________________________________________________________

My signature below certifies that I conducted training for the Head Start staff listed above.

_____________________________________________           ________________________
Signature                                                                                                                                                Date

The signatures listed below certify that the following Head Start staff received training on
administering medication for the child listed above:

____________________________________________  ________________________
Signature                                                                                                                               Date

____________________________________________  __________________________________
Signature                          Date

____________________________________________  __________________________________
Signature                                                                                                                                                   Date

This is to verify that I, ___________________________, was in attendance during this training
and that I concur with this established procedure.

_____________________________________________           ________________________
Parent’s Signature                                                                                     Date

_____________________________________________           ________________________
Witness                                                                                                           Date
# Medicine Quantity Verification Log

**Upper East Tennessee Human Development Agency, Inc.**  
**Head Start Program**

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Center</th>
<th>Teacher</th>
<th>Date Received Medication</th>
<th>Type of Medication</th>
<th>Quantity Received</th>
<th>Signature of Staff Receiving Medication</th>
<th>Signature of Parent/Guard.</th>
<th>Date Medication Returned to Parent/Guard.</th>
<th>Signature of Head Start Staff Returning Medication</th>
<th>Signature of Parent/Guard. Receiving Returned Medication</th>
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</table>

Compiled By: Children’s Services Staff August 15, 1997
Upper East Tennessee Human Development Agency, Inc.  
Head Start Program  
Dispensing Medication Log

*****IMPORTANT - Please refer to Form 4.08B, “Physician’s Instructions for Head Start staff to Administer Medication During Head Start Hours”

Child’s Name: ___________________________ Date of Birth ________
Center/Classroom: ___________________________

Medication to be administered: ___________________________________________

*Use a different sheet for each medication administered

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Dose</th>
<th>Staff Administering the Medication (Signature)</th>
<th>Witness to the Administering of the Medication (Signature)</th>
<th>Observed side effects/behavior changes</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Upper East Tennessee Human Development Agency, Inc.  
Head Start Program Child Accident Report

Date of Accident________________           Time of Accident______________

Center________________________                                     Teacher_____________________

Child’s Name:   __________________________________ Age:_______  D.O.B.___________

Gender □M  □F      Social Security Number xxx-xx__ __ __ __

Parents’/Guardians’ Names_______________________________________________________

Address:______________________________________________________________________

Phone # (include area code)(____)___________ Alternate Phone #_______________________

Place of Accident: ___________________________  Date of first treatment:________________

Describe How Accident Occurred:__________________________________________________
______________________________________________________________________________

Child's behavior after the accident:  _________________________________________________

Parent/Guardian notified by whom: _________________________________________________

By (Check One):  Phone: __________ Letter:__________     In person: ______________

Witness(s) to the accident: ________________________________________________________

Address: ________________________________________ Telephone:____________________

Location of Injury: (Check):     ankle _____,  arm ____, foot____,  leg____, hand____,

mouth ____ , nose____, head____, back____, stomach _____, other:____________________

Nature of injury: bruise____ cut _____scratch_____ fracture_____ other:___________________

Unsafe conditions noted: _________________________________________________________

Disposition of Case (check):  First-Aid at school: ___________, sent to hospital:_____________

sent to a physician: _____________ sent home:________________

Name and Address of hospital and /or physician treating child:__________________________

____________________________________________________________________________

Describe treatment:   ____________________________________________________________

Original: Assistant Head Start Director      Copy: Classroom
UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC.
HEAD START PARENTAL RELEASE
FOR
EMERGENCY MEDICAL AND/OR HOSPITAL TREATMENT

I give my permission for my child, ____________________________, to receive medical services and/or emergency medical treatment or to be taken to a physician, dentist, or local hospital.

I have a private Physician:  ____yes  ____no
Physician’s Name/Address:  __________________________________________
___________________ (Phone) ______________

I have a private Dentist:  ____yes  ____no
Dentist’s Name/Address:  __________________________________________

Child’s TennCare #: ______________________ Provider: _______________________
Address:           ______________________ County:  _______________________
Telephone:           ______________________ Center:   _______________________

Release and Waiver of Liability
The undersigned parent and/or legal guardian waive all claims for damages against Upper East Tennessee Human Development Agency (UETHDA) and its officers and employees for injury to our child’s person or property, including death and destruction, and resulting injuries and damages to us that may arise from this activity. We release UETHDA and its officers and employees and agree to hold them harmless from any such liability. The undersigned parent or legal guardian further states that he or she has carefully read the foregoing release, knows the content thereof, and signs it as his or her own free act and deed. This agreement shall remain in force until we revoke it in writing.

We are requesting that both parents or legal guardians sign this permission form. If both parents or both legal guardians are unable to sign this permission form, please indicate the reason below:

_____ I am the legal and sole custodial parent or legal guardian of this child. (Legal documentation has been provided to the Head Start Program.)

_____ The other parent or legal guardian is a non-resident and is not able to be contacted or whereabouts are unknown.

_____ Other, please explain: ______________________________________________________

Parent/Guardian: ___________________________                     Date: ___________________
 Signature

Witness:      ___________________________                     Date: ___________________
 Signature
Upper East Human Development Agency Inc., Head Start Program
Inventory for First-Aid Kit

<table>
<thead>
<tr>
<th>Item</th>
<th>Classroom ________________</th>
<th>Teacher ________________</th>
<th>Place an ‘X’ in the space indicated the item that needs to be re-stocked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two large gauze pads (5 x 9 inches)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhesive strips (1/2&quot; x 3/4&quot; x 1&quot;)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauze bandage (4 x 4 or 3 x 3, nonstick, sterile)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhesive Bandage tape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rolled flexible or stretch gauze (2 inches)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation pocket mask</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Triangular bandages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small splint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 elastic wraps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scissors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tweezers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directions for requesting emergency assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thermometer and Covers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flashlight with batteries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable latex gloves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial cold pack for ice cubes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soap (disinfectant)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat Thermal Survival Wrap</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealed package of cleansing wipes *(Check Expiration Date)</td>
<td></td>
<td></td>
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</tbody>
</table>

I certify that I have checked the first-aid kit in this classroom and the inventory above is accurate. I also certify that no other supplies are in the kit other than those listed.

FRS Signature ___________________________    Date ___________
Upper East Human Development Agency Inc., Head Start Program  
Inventory for BBP Control Kit

Classroom ___________________                 Place an “X” in the space indicated items that need to be re-stocked
Teacher _____________________

<table>
<thead>
<tr>
<th>Item</th>
<th>Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Sanitizer (4 oz. bottle)</td>
<td></td>
</tr>
<tr>
<td>Disposable Latex Gloves (1 bx.)</td>
<td></td>
</tr>
<tr>
<td>Spill Clean-up Pan and Scooper</td>
<td></td>
</tr>
<tr>
<td>Absorbent Z Solidifier (8 oz.)</td>
<td></td>
</tr>
<tr>
<td>Biohazard Label Infectious Waste Bags</td>
<td></td>
</tr>
<tr>
<td>Regular Disposable Waste Bags</td>
<td></td>
</tr>
<tr>
<td>Antiseptic Wipes (1 Bx.) *(Check Expiration Date)</td>
<td></td>
</tr>
<tr>
<td>Disposable Germicidal Cloth (2 pkgs.)</td>
<td></td>
</tr>
<tr>
<td>Personal Protective Mask (1)</td>
<td></td>
</tr>
</tbody>
</table>

Blood Borne Pathogen Exposure Control Plan on Site               _______      _______  (OSHA Compliance Kit)  
Yes             No

I certify that I have checked the first-aid kit in this classroom and the inventory above is accurate. I also certify that no other supplies are in the kit other than those listed.

FRS Signature _________________________    Date ___________
### FIRST AID KIT SUPPLIES CHECKED:

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>By (Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUGUST</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>SEPTEMBER</td>
<td>__________</td>
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<td>OCTOBER</td>
<td>__________</td>
<td>__________</td>
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<tr>
<td>NOVEMBER</td>
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<td>DECEMBER</td>
<td>__________</td>
<td>__________</td>
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<tr>
<td>JANUARY</td>
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<tr>
<td>FEBRUARY</td>
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<td>__________</td>
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<td>MARCH</td>
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<td>APRIL</td>
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<tr>
<td>MAY</td>
<td>__________</td>
<td>__________</td>
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</tbody>
</table>
Upper East Human Development Agency Inc., Head Start Program
Inventory for Bus First-Aid Kit

Bus Number: ______

(Place an X in the space indicating items that need to be re-stocked)

<table>
<thead>
<tr>
<th>Item</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adhesive Strips/Band-Aids</td>
<td></td>
</tr>
<tr>
<td>Gauze Pads</td>
<td></td>
</tr>
<tr>
<td>Rubber Gloves</td>
<td></td>
</tr>
<tr>
<td>Bandage Tape</td>
<td></td>
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<tr>
<td>Tweezers</td>
<td></td>
</tr>
<tr>
<td>Scissors</td>
<td></td>
</tr>
<tr>
<td>Cleaning Wipes *(check expiration date)</td>
<td></td>
</tr>
<tr>
<td>Spill Clean-up Pan &amp; Scooper</td>
<td></td>
</tr>
<tr>
<td>Biohazard Label Infectious Waste Bags</td>
<td></td>
</tr>
<tr>
<td>Absorbent Z Solidifier (8 oz.)</td>
<td></td>
</tr>
</tbody>
</table>

Teacher/Classroom ______________________         ___________

Received by ______________________          ___________

Date ______________________          ___________

Date ______________________          ___________
**UPPER EAST TENNESSEE HUMAN DEVELOPMENT AGENCY, INC.**  
**HEALTH SERVICES SCREENING LOG**

Head Start Classroom ________________________________       Date of Screenings________________

Screenings Completed by______________________________

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Vision Result</th>
<th>Blood Pressure</th>
<th>Dental Completed</th>
<th>Hearing (AuDX) Result</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

This is to certify that I received the results of the screenings listed above.

Name and Position (please print)______________________________________________

Signature____________________________________________________Date______________

Original: Signee
Yellow Copy: Quality Assurance Staff
Date: July 1, 2013

Child’s Name: ____(Child Name)________

Birth Date: ____ (7/1/09) ____________

This is to verify that the UETHDA Head Start Program will pay for a dental exam and estimate for ____(Child’s Name)________ at _______ (Dental Office)________ in the agreed upon amount of __$00.00______.

You may verify this letter by calling me at:
Martha Dixon, Q.A.
UETHDA Head Start
Cell: 423-384-8617
Office: 423-230-3707

Please send request for payment to:
UETHDA Head Start
301 Louis Street
P.O. Box 46
Kingsport, TN 37662
Attn: Martha Dixon

Head Start will only pay for services if this letter is presented at time of the appointment. If you have any questions, please contact me.

Sincerely,

Martha Dixon
Quality Assurance Specialist
UETHDA Head Start
E-Mail: Mdixon@uethdahs.com
Date:   ___(July 1, 2013)_____________________

Child’s Name:   ___(Child’s Name)_____________________

Birth Date:   ___(7/1/09)_____________________

This is to verify that the UETHDA Head Start Program will pay for dental treatment services for   ___(Child’s Name)________ at   ___(Dental Office)_____________.  
The estimated amount for payment for these services is   ___($00.00)_____________.

You may verify this letter by calling me at:  
Martha Dixon, Q.A.  
UETHDA Head Start  
Cell: 423-384-8617  
Office: 423-230-3707

Please send request for payment to:  
UETHDA Head Start  
301 Louis Street  
P.O. Box 46  
Kingsport, TN 37662  
Attn: Martha Dixon

Head Start will only pay for services if this letter is presented at time of the appointment. If you have any questions, please contact me.

Sincerely,

Martha Dixon  
Quality Assurance Specialist  
UETHDA Head Start  
E-Mail: Mdixon@uethdahs.com
Date:    (July 1, 2013) ______________________
Child’s Name:  (Child’s Name) ______________________
Birth Date:   (7/1/09) ______________________

This is to verify that the UETHDA Head Start Program will pay for a physical for ______ (Child’s Name)_______ at the ______(Name of Health Department)____ County Health Department in the contracted amount of $50.00. Please do not include vision, hearing, or developmental screening as these have already been completed by the Head Start program.

You may verify this letter by calling me at:
   Martha Dixon, Q.A.
   UETHDA Head Start
   Cell: 423-384-8617
   Office: 423-230-3707

Please send request for payment to:
   UETHDA Head Start
   301 Louis Street
   P.O. Box 46
   Kingsport, TN 37662
   Attn: Martha Dixon

*Head Start will only pay for services if this letter is presented at time of the appointment. If you have any questions, please contact me.*

Sincerely,

Martha Dixon
Quality Assurance Specialist
UETHDA Head Start
E-Mail: Mdixon@uethdahs.com
Date: ___(July 1, 2013)__________________________
Child’s Name: ___(Child’s Name)_____________________
Birth Date: ___(7/1/13)___________________________

This is to verify that the UETHDA Head Start Program will pay for a vision exam for ___(Child’s Name)__ at ___(Provider Name)__ in the contracted amount of $50.00. Head Start will also pay for eye glasses, if needed, at the current TennCare reimbursement fee.

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Cell: 423-384-8617
Office: 423-230-3707

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UETHDA Head Start
301 Louis Street
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