

A Needs Assessment:
Health Status of Migrant Preschool Children
Attending Migrant Head Start
by Roberta Packard RN, BSN

A Master's Research Project

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Abstract

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AUTHOR: Roberta Packard RN, BSN

This descriptive study is a health needs assessment of secondary data from 109 children aged six months to three years attending a Migrant Head Start (MHS) program in northwest Oregon during 1993. Results of health screenings, physical exams, acute care encounters and family information was collected from MHS records.

The health problems identified were anemia, dental caries, growth delays and positive TB skin tests, otitis media, and conjunctivitis. Relationships were found between alterations on physical exam and number of acute care encounters, as well as between Medicaid status and screening results. Results can be generalized to children meeting MHS criteria and children who received physical exam at MHS. This study can assist the program to understand the health status of the population and to better serve their needs.

APPROVED: _____

Caroline M. White, RN, DrPH, Professor

APPROVED:

[REDACTED]

Caroline M. White, RN, DrPH, Professor

[REDACTED]

Darlene A. McKenzie, RN, PhD, Associate Professor

[REDACTED]

Carol A. Lindeman, RN, PhD, FAAN, Dean

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION	PAGE
Introduction	1
Significance of the problem	3
The problem	4
Chapter 2: REVIEW OF THE LITERATURE	
Introduction	5
Review of the literature	5
Conceptual framework	17
Research question	24
Chapter 3: METHODS	
Overview	26
Design	26
Sample	26
Setting	28
Data collection	29
Chapter 4: RESULTS	
Sample	39
Results	40
Summary of major findings	59

Chapter 5: DISCUSSION

Meaning of findings	61
Limitations	66
Implications for practice	68
References	81
Appendixes	
A. Health Indicator Collection forms.....	87
B. Coding sheets	88
C. Migrant Head Start health forms	89
D. Age appropriate screens	90
E. Consents for study	92

LIST OF TABLES

Table 1. Studies on the Health Status of Migrant Children	14A
Table 2. Frequency of Primary Language for Parents of Migrant Preschool Children.....	40
Table 3. Frequency of Screening Results for Height, Weight, and Head Circumference of Migrant Preschool Children	42

Table 4.	Frequency of Screening Results for Vision, Hearing, and Dental Exams for Migrant Preschool Children	43
Table 5.	Frequency of Age Appropriate Immunization Rates for Preschool Migrant Head Start Children 6 Months to 3 Years of Age	45
Table 6.	Frequency of Number of Alterations in Health for Migrant Preschool Children at Physical Exam	47
Table 7.	Frequency of Health Alterations Diagnosed at Physical Exam for Migrant Preschool Children	48
Table 8.	Frequency of Multiple Acute Care Encounters	50
Table 9.	Frequency of Health Alterations Diagnosed at Acute Care Encounters for Migrant Preschool Children	51
Table 10.	Education Levels of Migrant Families ...	55
Table 11.	Frequency of Co-morbidities Diagnosed at Acute Care Encounters for Migrant Preschool Children	58

Chapter 1

Introduction

During the months of May through October in Oregon, Migrant Head Start (MHS) programs provide care for children of migrant farmworkers. It was estimated that 9,209 farmworkers (Migrant & Indian Coalition, 1993) came to the county served by one MHS program. Migrant farmworkers primarily came to this fertile agricultural county because of the employment opportunities provided by the need for hand labor to harvest the 19.5 million dollar small fruit and berry crops (Oregon State University Extension Service, 1991). Migrant families meeting program criteria for income and mobility are eligible to enroll their children in the MHS program. Approximately 807 children ages birth to six years were eligible for MHS in 1991 (Migrant & Indian Coalition, 1993). Families meeting MHS eligibility criteria are considered to be among the poorest of the working poor.

Migrant farmworker life is stressful in part because of problems enforcing regulations related to work and living, and in part due to limited choices for

these people. Choices regarding employment are limited because many migrants have minimal formal education and limited ability to speak English. Migrant families experience such problems as overcrowding, unsanitary housing, stress on the family unit and inadequate health care. For migrant children, education is the way to attain a better life than that of their parents.

The role of the MHS program is to prepare children for participation in the educational system.

Preparation includes health, social and emotional readiness for grade school. For children to benefit from the MHS they need to be in the best health possible. Head Start Performance Standards (U.S. Department of Health and Human Services, 1984) for the MHS health component require children attending Head Start Programs to receive a variety health screening tests, a physical exam and follow-up for problems identified.

In addition to providing preventive health services the MHS program in northwest Oregon also provides the children acute health care services. Acute health care services are services provided by a nurse practitioner at the school for children who come to school ill or become ill at school. The nurse practitioner examines and diagnoses sick children, writes prescriptions and makes referrals. These

services are provided because of the long hours that parents work, difficulties parents experience missing work for diagnosis, treatment and care of sick children; and the language, cultural, financial, and transportation barriers to accessing health care.

Preventive and acute health care services at the MHS setting are the responsibility of nurses and health workers. A pediatric nurse practitioner provides diagnosis, treatment and referral of children with acute care needs. A MHS program health specialist (R.N.), a center nurse (R.N.) and nonprofessional staff coordinate all health services. County community health nurses assist with immunization and communicable disease follow-up. The majority of the health services received by the children at this MHS are coordinated and delivered by nurses.

It is vital that the health status of the migrant children be known and understood. MHS has the responsibility to provide screening, diagnosis and treatment for alterations in health. Nurses participate in planning, delivering and evaluating health care to children attending MHS. In 1992 the National Advisory Council on Migrant Health published eight recommendations for inclusion in farmworker programs to assure the safety and health of all Americans. One of the Council's eight recommendations

called for an increase in research on the state of health of the farmworker population (National Advisory Council on Migrant Health, 1992). Considering the magnitude, scope and complexity of the health problems facing the Hispanic population, too few researchers have been involved in defining and solving these problems (Furino & Munoz, 1991).

The problem addressed by this study is the lack of information about the preventive and acute care needs of the population of migrant children ages six months to three years of age attending a MHS program in the Northwest.

Chapter 2

Review of Related Literature

Introduction

To gain a perspective on the health problems of migrant infants and preschool children the literature review begins with information on health status and health problems of the general child population in the U.S.. The review focuses on the problems of minority children within the general population, then more specifically the minority group of Hispanic children and finally the health problems of migrant children who represent a special group within the Hispanic population. The review concludes with a summary of the limitations of the literature reviewed.

Child Health and Head Start

The World Health Organization's definition of health is "the state of complete physical, mental and social well being" (Whaley & Wong, 1987, p.4). The Head Start program provides every enrolled child with a comprehensive health program that includes medical, dental, nutrition and mental health services (U.S. Department of Health and Human Services). To qualify for Migrant Head Start (MHS) the income of a child's family must be within Federal poverty income guidelines (Migrant and Indian Coalition, 1991). For 1993 the Head Start poverty line for a family of four was

\$14,350 (U.S. Department of Health and Human Services, 1993).

Health Status

General Population

Major health concerns for children in the U.S. include unintentional injuries, respiratory illnesses, violence directed at children, developmental problems and development of healthful habits (U.S. Department of Health and Human Services, Public Health Service, 1991). Specific objectives have been identified by the U.S. Public Health Service (1991) for decreasing the number of children experiencing child abuse and neglect, growth retardation, dental caries, infectious diarrhea, middle ear infections, pneumonia, iron deficiency, and inadequate immunization.

Low Socioeconomic Population

Children in low income families are in poorer health than children from families with more money (Kovar, 1982). Higher prevalence of mental retardation, learning disorders, emotional and behavioral problems, vision and speech impairments have been found in children of low socioeconomic status (U.S. Department of Health and Human Services, Public Health Service, 1991).

Health problems. Health problems for a group of 841 underinsured and uninsured children in Wisconsin

participating in a state funded pediatric nurse practitioner primary care initiative (Weis and Sharpton, 1993) included otitis media, congenital hip dysplasia, abnormal lab results, vision abnormalities and inadequate immunization.

In one study of 110 preschool children from low socioeconomic families attending a metropolitan Head Start program, half of the children had health deficits. These deficits were dental caries, anemia and developmental delays (Keltner, 1992).

Immunization status. The U.S. Public Health Service (U.S. Department of Health and Human Services, Public Health Service, 1991) in 1989 estimated that 70-80% of children under age 2 had received basic immunization series. Three out of every 10 children two years of age are not immunized and as many as 50% of two year olds from low socioeconomic populations were not fully immunized (Beister, 1992).

Among a group of 1476 predominately black and Hispanic children the identified predictors of future delays in immunization were the status of the child's immunization at three months of age and in-migration to the area of residence as compared to being born in the area (Centers for Disease Control, 1992). In addition, the Centers for Disease Control report that 23-33% of the children had not received a first dose of DTP by

three months of age.

Adequate immunization for minority preschool children has been a frequently identified problem (Centers for Disease Control, 1992; National Vaccine Advisory Committee, 1991; American Academy of Pediatrics, 1989; Slesinger, Christenson and Cautley, 1986; Smith, De Angelis, and Hanser, 1978).

Hispanic Minority Children

Race and ethnicity. Precise information about the health problems of Hispanic children in the United States is difficult to obtain because criteria for classifications by race and ethnicity vary. Many groups are included in the classification Hispanic.

While the term Hispanic has been used for many generations, it was not until 1970 that the U.S. Bureau of Census tried to study Hispanics as a separate group. Marin and Marin (1991) explain that the use of Hispanic by the government as an ethnic label is the product of a decision in 1978 by the Office of Management and Budget (OMB) to operationalize the label for a person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin regardless of race. The OMB definition generally excludes Brazilians, Portuguese, Cape Verdeans and Philipinos from the Hispanic definition. Reports of health data on groups identified as Hispanic often do not provide

clear information on precisely which group or groups are being discussed. The lack of Hispanic identifiers in national data sets can result in a weak foundation for research (Ginzberg, 1991; Furino and Munoz, 1991).

Population growth. The recent Hispanic immigrant population of the U.S. is increasingly from Mexico and Central America. In 1987 it was estimated that 11.8 million U.S. residents were of Mexican origin, and that the Hispanic population was increasing at five times the rate of the total population (Warner, 1991). At the beginning of the 1990's, Hispanics made up 8% of the total U.S. population. The population had a median age of 26 compared to 33 years for the general population and in 1987 a birth rate of 22.3 per 1000 women compared to 15.7 per 1000 women in general population (U.S. Department of Health and Human Services, Public Health Service, 1991). By the year 2000 Hispanics will be the largest minority in the United States (Furino and Munoz, 1991).

Socioeconomic problems. Compared to the U.S. white population, Hispanics are more likely to live in poverty (Mendoza, Ventura, Valdez, and Castillo, 1991; American Medical Association, 1991), be unemployed or underemployed, have little education, have high fertility rates and no private insurance (American Medical Association, 1991). The health status of

Hispanic children in the U.S. has become an important national issue as a result of this population's rapid growth and poverty (Mendoza et al., 1991; U.S. Department of Health and Human Services, Public Health Service, 1991).

Health status. High morbidity from childhood diseases preventable by immunization and from bacterial gastroenteritis diseases, tuberculosis, depression, dental caries, periodontitis, and illness from acute and chronic pesticide exposure significantly impact the health status of Hispanic children (Furino and Munoz, 1991).

A study of data from the 1987 National Vital Statistics System and the Hispanic Health and Nutrition Examination Survey (1982-1984) assessed the health status of Hispanic (Mexican-American, mainland Puerto Rican and Cuban-American) children (Mendoza et al., 1991). In this study 3622 Mexican-American children showed a lower prevalence rate for chronic medical conditions (3.93% +-SEP.84) than for 1289 mainland Puerto Rican children (6.24% +-SEP.66). The results for 387 Cuban-American children were considered too small to be reliable, only reflecting attributes of the examined subjects. Chronic conditions experienced by Mexican-American children in order of most frequently occurring conditions were: cardiovascular diseases,

mental/central nervous system disorders, metabolic, nutritional and blood disorders, congenital anomalies, genitourinary/gastrointestinal diseases, eye and ear disorders. While the Mexican-American children were less likely to have a chronic medical condition identified by history alone when compared to the Puerto Rican children, the parents of the Mexican-American children were less likely to have consulted a physician for their child's chronic condition. Almost one in five of the Mexican-American children required referral within the month for their conditions (Mendoza et al., 1991).

Health assets. It is important to note that Mexican-American children born to mothers from Mexico enter the world with generally good health and birth weight (Mendoza et al., 1991; National Advisory Council on Migrant Health, 1992; Ginzberg, 1991). These same authors note that the positive health assets of Mexican-American infants are most likely the result of Mexican mothers not smoking or drinking during pregnancy.

Health beliefs and practices. Approaches to health and illness among Mexicans have been influenced by beliefs, customs (Gonzalez-Swafford and Guiterrez, 1983) as well as policies of the Mexican government emphasizing curative medical care (Stebbins, 1986). In

general people of traditional Hispanic culture regard health and illness as connected to harmony between the natural and supernatural. Illness reflects on an individual's relationship with the community and God.

Physical illnesses are generally believed to be due to an imbalance in the body between hot and cold (Gonzales-Swafford and Guitierrez, 1983). A system of folk medicine developed to restore harmony to the body and spirit when relationships become unbalanced (National Advisory Council on Migrant Health, 1992). Mexican-Americans may use three general types of treatment for physical illnesses: home remedies of herbs prescribed by women with healing knowledge (cuananderas); antibiotics and other medications prescribed by health professionals; and medications purchased over the counter (Higginbotham, Trevino and Ray, 1990; Gonzales-Swafford and Guitierrez, 1983).

Hispanic Migrant Children

Migrant population

In 1991 (Ginzberg) noted that about 9% (4.2 million) of Mexican-Americans are particularly disadvantaged because they are employed in seasonal, low wage agricultural jobs. Slesinger et al. (1986) and Dever (1992) point out that very little is known about the health status of migrant and seasonal farmworkers.

Studies focused on the health of migrant children.

Work by Steffen and Francis (1978) and studies by Smith, DeAngelis and Hanser (1978), Slesinger, et al., (1986), and Dever (1992) comprise the majority of the published studies and information on the health status and problems of migrant children.

Steffen and Francis's (1978) work was performed while working among Mexican-American migrant children in clinic and school settings. Dever's (1992) study was based on information from migrant health clinics and identified the most frequent reasons for clinic visit for children as well as some information on co-morbidity patterns. Slesinger et al., (1986) study of migrant women and their children utilized interviews with mothers to obtain health information about immunization, well child check-ups, dental visits, and hospitalization. Smith et al., (1978) reported on the health screenings of migrant children age two months to 16 years old. These four studies and their findings are summarized in Table 1.

The incidence of co-morbidity conditions was identified in two of the studies. The study by Smith et al., (1978) identified health problems in almost half the children and co-morbidity (two conditions) in 5.8% of the children. In the study by Dever (1992) the highest percentages of co-morbidities were in the <1

Table 1.

Studies on the Health Status of Migrant Children

AUTHOR(S), publication date	YEAR data collected	SAMPLE	LOCAL	SOURCE OF DATA	RESULTS (selected)
Steffin and Francis (1978)	1975	Mex-American migrants & settled out migrants. No sample size, no method of selection.	Utah Migrant day care centers & county health department well child clinics	School health screenings & well child clinic screenings.	Results not quantified, health problems most frequently observed: dental caries, iron def. anemia, delays in immuniz- ation, skin lesions, otitis media, low growth measurements, speech & hearing disabilities, cardiac, orthopedic problems.
Siesinger, Christenson and Cautley (1986)	1978	10% random sample of all workers from every employer using migrant workers. 330 Hispanic children < 16 years old.	Wisconsin	Administered questionnaires	< 3 yrs old - immunization rates 43-77%, TB skin test-37%. 3-5 yrs old immunization rates 73-90%, TB skin test-69%. < 5 yrs old - ck-up in past year 50%. Never had dental ck, < 3 yrs old-73%, 3-5 yrs old-34%.
Smith, De Angelis and Hanser (1978)	1976	327 Mex-American children 2 mo. to 16 yrs old enrolled in day care.	Wisconsin school day care	Health screenings	Health defects- 49% anemia-16.5%, EMT-12%, skin-9%, eye-3%, respiratory infection-2.7%, orthopedic-2.4% poss.congital heart cond.-1.8%, morbid obesity-1.8%, developmental-1.5%, severe dental caries-1.2%, misc.-4%.
Dever (1992)	1986-87	6969 clinic visits for Hispanics of which 2355 were children < 10 yrs old.	Migrant health centers in Michigan, Indiana, Texas	Clinic visits	< 1 year to 4 yrs. of age, visit in order of most frequent, health visit, acute URI, consult, otitis media, colitis, eye infection, candidiasis, anemia, strep. infection, malnutrition.

year old, 1-4 year old and >64 year old groups. The co-morbidity averages were 2.3 for the <1 year old group, and 2.0 for the 1-4 year old group. Co-morbidities were similar for males and females. Dever notes that the co-morbidity patterns observed in his study suggest that the migrant population is a vulnerable group and that co-morbidities have the ability to produce substantial disability.

The subject of co-morbidity in the population of migrant children raises questions about identification of the patterns of co-morbidity, the reasons for certain conditions to appear together which conditions may be precursors for other conditions and how prevention and intervention could help to reduce the incidence of problems.

Summary

Limitations of Studies Reviewed

Review of the literature shows very limited information about the health problems of Mexican-American children of preschool age. Studies about Hispanic migrant children are very limited (three studies) and contain limitations related population, methods and setting.

All of the studies in this literature review concerned the population of the Midwest migrant stream; no studies were found concerning the Western stream

that travels to the Pacific Northwest. No mention was made to any part of the migrant population being of indigenous heritage (Mayan Indian), although in the Northwest this population is being seen more frequently in the migrant stream. It is difficult to generalize study results from one population to another when there is very limited information about the populations themselves. Differences in language, beliefs, educational level, acculturation and previous history of access to health care are considerations when comparing populations.

Half the studies of children presented information in an aggregate format so that it was not possible to determine the health problems of specific age groups such as infants, toddlers and preschoolers. The prevalence of alterations in health are often related to the age of the child, so that generalizing from an aggregate of birth to 16 year olds to two and three year olds can result in inappropriate conclusions.

The studies all occurred between 1975 and 1987, making the most recent information seven years old. As standards for health maintenance such as type and schedules for immunization and well child exams change it becomes increasingly difficult to compare data collected under differing standards.

Methods used to collect information also had some

major limitations. The study by Slesinger et al. (1986) relied on verbal histories from the mothers to obtain specific information on the immunizations, checkups, dental visits, hospitalizations and chronic conditions of their children. It is significant to note that 35% or more of these mothers were functionally illiterate and had an average of 4.3 children (Slesinger et al., 1986). This method of obtaining data relies totally on the mother remembering and remembering correctly detailed health data for each of her children. While Slesinger et al. (1986) relied totally on the mother for health data, the study by Smith et al. (1978) did not include information from parents and relied only on screening and physical exam to evaluate health status.

The settings for the studies were migrant health clinics (Dever, 1992; Steffen and Francis, 1978), school (Steffen and Francis, 1978) and an unknown interview setting (Slesinger et al., 1986).

While all of the studies referred to the difficult life of the migrant family only Steffen and Francis (1978) addressed the implications of culture on the population studied.

If MHS is to plan, coordinate deliver and evaluate health services that are also culturally appropriate it will be necessary to have as clear a picture of the

health problems of the preschool child as possible.

Because there are some significant differences in culture and beliefs between the migrant population and the North American health care providers, Leininger's (1985) Sunrise Theoretical/Conceptual Model of Transcultural Care Diversity and Universality was chosen as the conceptual framework for this study. The model explains that while different cultures perceive, understand and practice care in different ways there are some commonalities about care in all cultures. The MHS program and migrant parents have in common their care for the migrant children. This shared caring for the children includes care related to their health status. It was toward the shared purpose of caring that this study on the health status of the migrant children was conducted.

The purpose of this study was to identify the health status of a sample of migrant preschool children from the Western migrant stream attending a Migrant Head Start program in Oregon during 1993.

Conceptual Framework

This study draws on the experience of the researcher who has worked as a nurse at the study site. All of the infants and children attending the MHS program at the study site were from Mexican or

Guatemalan families. The majority of the families were Spanish-speaking Mexicans and a minority were families of Mayan Indian ancestry who spoke one or more Mayan dialects (there are 23 dialects) and varying amounts of Spanish. In the school setting there were daily reminders of the culture of the migrant families: a small child wearing an amulet, a note from a parent requesting their child not be bathed that day due to concern about becoming cold, or a mother discussing the use of an herbal tea for the symptom of an illness.

Attending to the health needs of such children is an example of transcultural nursing as described by Leininger (1978). Transcultural nursing is the comparative study and analysis of cultures regarding their caring behavior; nursing behavior; and health-illness values, beliefs and behaviors. Its purpose is to develop a scientific and humanistic body of knowledge and thus provide culture specific and culture-universal nursing care practices.

Leininger (1985) defines caring as "actions to assist, support or facilitate another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway" (Leininger, 1985, p.209). Identification of the differences and similarities in care among cultures provides a knowledge base that nurses can use to guide nursing

care, decisions, and actions that are beneficial to clients.

From her work with 30 cultures Leininger (1978) developed a conceptual model to represent transcultural and ethno nursing constructs. By the 1980's she had developed the Sunrise Theoretical/Conceptual Model of Transcultural Care Diversity and Universality: A Theory of Nursing, a theory that can help discover what care means to people of various cultures.

As a theory explaining and theory generating model the Sunrise Model is comprehensive, composed of numerous defined concepts, and is focused on discovering what care means to various cultures. As a theory explaining model, The Sunrise Model describes various social structure and world view factors that influence health through language and environment. In turn these factors influence folk, professional and nursing systems and according to Leininger nurses must consider these factors to know human care and health.

As a theory generating model The Sunrise Model defines the four levels of abstraction and analysis in which care can be studied. Level I studies social systems and perceptions from micro level (small scale studies involving individuals within a culture), middle level (a larger scale study of complex factors in a specific culture) and macro level (study of large scale

phenomena such as several cultures). Level II is the study of health within individuals, families, and cultures for special meanings and expressions in the context of a health system. Level III is the study of folk and professional systems for the characteristics and specific care features of each to determine similarities and differences. Level IV is used to develop nursing care that is harmonious and valued by cultures. Additionally the model incorporates both fundamental and applied knowledge of universal and diverse care.

In a general overview of The Sunrise Theory Leininger (1985) defines 10 central concepts. Three of these concepts are culturally-based nursing care actions predicated to be congruent and beneficial to clients. These actions include culture care maintenance, culture care accommodation, and culture care restructuring. Leininger (1985) defines culture care maintenance as "those culturally based assistive, facilitative or enabling phenomenon [sic] that help individuals to maintain favorable health and caring lifeways" (p. 210); culture care accommodation as "those culturally based assistive, facilitative or enabling phenomenon [sic] that reflect ways to adapt, negotiate or adjust to individual or the client's health and care lifeways" (p. 210); and " cultural care

restructuring as reconstructed or altered designs to help clients change health or life patterns that are meaningful to them" (p. 210).

The three concepts of culture care preservation, culture care accommodation and culture care repatterning are especially important for the providers working with migrant families. By incorporating these concepts into the provision of care the provider will support the families positive care features and will promote incorporation of North American health care practices into migrant health care practices. An example of culture care preservation is the support a provider could provide for a migrant woman breast feeding her baby or young child. Breast feeding is the preferred method of feeding in the Mexican and Guatemalan cultures and provides many benefits to the child and the mother including nutrition, safety, low cost, as well as physical and emotional satisfaction. An example of culture care accommodation is offering services such as immunization, physical exams and dental exams to children at times when parents can be present. Offering these services in the early evening after parents get off work and before children go to bed is an example of the provider adjusting to the migrant families way of life. Counseling parents on ways to reduce the risk of baby bottle tooth decay is

an example of culture care repatterning. Mexican and Guatemalan cultures want their children to be happy and content so they frequently let their children have a baby bottle at night and during the day until the child is two or three years old. By encouraging parents to gradually replace the juice, milk, or Cool Aide in the child's bottle with water (for the times other than meals), the child can still have the comfort of a bottle, but not the risks created by constant contact with sugar containing drinks.

A provider treating a child for health problems needs to be aware of the numerous factors that can influence the parents care of the child. A child from a nonliterate Spanish or Mayan speaking migrant family needing surgery presents a number of considerations. These considerations include communicating with the parents about the surgery in a manner that will facilitate their understanding of the process (i.e., not allowing the child to eat or drink before surgery, child must be free of illness), follow-up care and appointments, transportation to the hospital, translator at the hospital, concerns about loss of income and or loss of job if the parent misses a day of work, provision of child care for other children in the family, concern about paying for surgery if not covered by Medicaid, and concern about legal status if applying

for financial assistance to pay for the surgery. One of the most important keys to successfully working with families from other cultures is to acknowledge as Leininger does the many social structure and world view factors which influence care and health of human beings as individuals, families and cultural groups in health systems.

Providing health care to a population whose culture is different from the dominant population in terms of language, beliefs and practices is a major challenge for Migrant Head Start programs. Observant, caring and motivated providers can learn over time to provide care in a manner that is appropriate for the population they serve. Leininger's theory of nursing provides a conceptual framework for explaining multiple factors affecting care and health and can assist in building a bridge of understanding between peoples of different cultures.

The data from this study regarding the health status of a group of migrant preschool children were derived from records that were based upon required Federal government program standards and are limited from a cultural perspective. The data will indicate health issues from a Western medical perspective that need to be addressed in the context of cultural forces in the migrant population. One of the greatest

challenges for the MHS program is compliance with Federal standards in a manner that facilitates culture care maintenance, culture care accommodation, and culture care restructuring.

Research Question

The over-all purpose of this study was to help answer the question: what is the health status of a group of children ages six months to three years old attending a Migrant Head Start program during 1993? More specifically the following questions were addressed:

1. What is the frequency of selected socio-economic risk factors?;
2. What is the frequency of normal and abnormal values on selected screening parameters?;
3. What is the frequency of selected alterations in health discovered by physical exam and what are the average number of alterations per child?;
4. What are the presenting problems at acute care encounters and what is the frequency of multiple encounters per child?;
5. What is the inter-relationship among results of screening, physical exam and acute care encounters for children in the study?;
6. What are the socio-economic status factors for

children who scored above the median in the areas screening, alteration and encounters?;

7. What are the most frequently occurring co-morbidities, what is their frequency in the sample and what are the percent of encounters with more than one problem identified?;

8. How does the health status of this sample of children in a MHS program compare to Healthy People 2000 (U.S. Department of Health and Human Services, Public Health Service, 1991), for those parameters for which there are standards?; and

9. How does the immunization status of this sample of MHS children compare to Oregon's immunization rate for the same age group in this study and what is the frequency of over-immunization for MHS children ?

Chapter 3

Methods

Overview

Head Start Program Performance Standards provide specific guidance for the health services to children enrolled in Migrant Head Start (MHS) programs. Records of these services provide potentially rich sources of data. For this study the health records were reviewed to determine their health status of 109 children six months to three years old who were enrolled and attending a Migrant Head Start program in northwest Oregon in 1993.

Design

The design for the study was descriptive. Its purpose was to describe the health status of the children ages six months to three years of age based on the health records and social service records maintained by the program.

The Sample

From a population of 336 children enrolled and attending the MHS program in 1993 and who had a physical exam during their participation in the program, all of the children ages six months to three

years of age were selected. These 104 children included in the study were six months to three years of age as of May 3, 1993, the first day of class for MHS in 1993. (There were a small number of children enrolled in the program who were six weeks to five months of age and a larger number of children who were >3 years of age to almost six years of age.) Selection of children for inclusion in the study group was based on physical exam, because documentation for the physical exam provides significant information that could not be obtained from other sources. This young age group was selected because health information about these children is limited and because such young children are not included in many Head Start programs. During 1993 the MHS program staff sensed that there might have been many health needs among this group, but confirmation of the six month to three year old group's health status had not been made prior to this study.

Limitations of this sample could include the problem of leaving out children who came into and left the program before they received a physical exam and children absent on the day they were to receive a physical exam.

The MHS program operated from May through the end of October (six months). Data regarding the length of time a child participated in the program was not

consistently available and so could not be included in this study. Children attending the program for longer periods of time could potentially have more health data and acute care encounters and health problems in their health records. Since the age of the children advanced over the time of program, some children became old enough for some screening examinations after the first day of school, as was the case of the children who became three years old during the program and thus became old enough for vision screening. This form would not be completed at the time a child came in for acute care; thus, the sample is not biased toward children seen for acute problems.

All of the children attending the program were from Mexican or Guatemalan families. The majority were born in the U.S.. The majority of the families considered Spanish their first language and a small minority spoke one or more Mayan dialects and some Spanish. Generally parent's formal education was limited.

Setting

Children attending this northwest MHS program came from a radius of approximately 25 - 30 miles of the school sites. The program was operated at four locations, three were located within a mile of each other in a mid-sized town, and the fourth was located

in small town six miles away from the other three locations.

Families lived in a variety of settings which include apartments, apartments shared with other families or individuals, labor camps, houses shared with other families and sometimes families live in their vehicles or in shelters. Most children rode to school on MHS school buses.

The program operated from May through October, to coincide with the need for laborers to harvest crops in this highly agricultural area. The data in this study was collected for the time period from May 3, 1993, to October 29, 1993.

Data Collection Measures and Procedures

For the study described here a health indicator collection form was developed by the investigator (see Appendix A). Information was entered as indicated on the coding sheet (see Appendix B). The health indicator form brings together information specified by this study from numerous sources in the child's school file. Each child's health and social service record was reviewed by the researcher to obtain the information for this study. Screening results and demographic information were transferred directly from the record to the health indicator collection form. The results of the physical exam and acute care

encounters were abstracted from the records and entered on the health indicator collection form. The researcher was familiar with the record system and the reliability of the data collection procedure was very good.

The data for screenings were based on specific Head Start Performance Health Standards and accepted health screening instruments used in school settings. To be reliable, screening instruments should consistently measure the attribute it is suppose to measure, such as a the results of vison screening exam determining which children needed further vision evaluation. For a screening instrument to be valid it should measure what it is intended to measure, such as dental screening results should measure the health status of the child's teeth and gums. The screening instruments were considered reliable and valid.

Sources of Data

The following data sources were selected for this study to provide as complete a picture of the children's health status as possible from information routinely collected during the child's participation in the MHS program (see Appendix C for a sample of each data source).

1. Health history
2. Emergency procedure form

3. Growth charts
4. Dental screening form
5. Special needs file contents form
6. Certificate of Immunization Status
7. Physical exam form
8. Vision screening form
9. Enrollment application form
10. Problem list/progress notes.

At the time a child was enrolled into the MHS program information for the health history, emergency and enrollment forms and Certificate of Immunization Status were obtained by social service and health staff. Other forms in the child's file were completed during the program. Data items are discussed with reference to form from which they were retrieved, in order that the way in which they were assessed initially might be clear, and their potential reliability and validity inferred.

Health history: Contained information about the child's health which was obtained by social service or health staff from the parent(s) at the time of enrollment or before the child's first day of school. The history was obtained by asking parents standard questions in Spanish and recording the responses in English on the form. The health history was the source of data in this study for date of birth, gender, place

of birth (country) and if the child was born premature.

Emergency procedure form: Included information about where to contact parents during work hours, family home address, and basic information about medical conditions of child. The form was completed by social service at the time of enrollment by staff asking parents questions in Spanish and recording responses in English on the form. For this study the emergency procedure form provided information about the child's Medicaid status.

Growth chart: A recording of the child's height, weight, and head circumference (if less than 1 year old) was made by health staff during the program.

Measurements were graphed on a standardized growth graph to provide a comparison of the measurements with other children of the same age and sex and displayed as percentiles. For this study children with percentiles for height, weight, or head circumference greater than 95% were noted as large and children less than 5% as small; others were coded as normal. Missing data was also noted.

Dental screening form: Dental screenings were done during the time frame of this study as long as resources were available starting with the older children and this form was completed by a dentist after a cursory exam of the child's mouth. Some of the older

children in the study group received a dental screening. Head Start performance standards identify a priority system for children in most need of dental care which was used in this study.

priority 1 - "children who have special needs requiring immediate action, i.e. painful teeth/or gums, badly decayed teeth/obvious large cavities, swelling and bleeding or pus formation around the gums.

priority 2 - children with observable decayed teeth/cavities.

priority 3 - children with no observable disease who require a dental examination and any necessary preventive dental care services." (U.S. Department of Health and Human Services, 1984, p.29)

Special needs file contents form: A listing of the documentation about the status of a child with disabilities. Disability conditions included: health impairment, learning disabilities, emotional/behavioral disorders, speech or language impairment, visual impairment, autism, traumatic brain injury and other impairments (U.S. Department of Health and Human Services, 1993). The disabilities coordinator was responsible for maintaining the file and monitoring the evaluation process for children who may meet the disabilities criteria. In this study children were

designated as having no qualifying conditions, or as meeting criteria or being in the process of evaluation to meet criteria.

Certificate of Immunization Status (CIS): A form required by the state for documenting immunizations and used by MHS for documenting tuberculosis skin testing. The form was filled out at enrollment by health or social service personnel from the parent held record of immunization. Parent held records can originate from any state in the U.S. or Mexico or Guatemala or a combination of these locations. Mexico and Guatemala do not have the same requirements for immunization as the United States. The CIS provides information about immunization against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, haemophilus influenza and hepatitis B, as well as TB skin test results. In this study each immunization series (DTP, OPV, MMR, Hib., or Hep. B) was noted as being either complete, or incomplete and not up to date, or incomplete, but up to date as specified by state immunization standards for age appropriate immunizations. Note was also made in this study of children receiving more immunizations than the standards recommend. TB skin test results were recorded as negative (0 to 10 X 10 m.m. induration), or positive (>10 X 10 m.m. induration) or test given but not read, or data missing or test not

applicable (child <1 year of age or child with previous positive test).

Physical exam form: This form was completed by a nurse practitioner documenting a child's undressed physical exam of all body systems. The exam was performed once during the MHS program. For this study the status of the child based on the physical exam was either a well child or a child with one or more alterations in a body system. Identified alterations included: otitis media, respiratory infection, candida infection, gastroenteritis, conjunctivitis, dermatologic condition, or other condition.

The results of audiometric testing were entered on the physical exam form or health tracking form by MHS health staff. The screening was performed by an audiologist on children age three or older at intervals of every two years. For this study a child's status was either pass, or fail. For children less than three years of age a gross hearing screening was performed by ringing a bell (by MHS health staff) out of sight of the child and observing to see if the child turns toward the sound or stops activity at the instant the bell was rung. Status for the gross screening was the same as for audiometric screening.

A microhematocrit was obtained on children over age one and this information was entered on the

physical exam form by the health professional performing the test at MHS. Some hematocrit results were obtained from the Women Infants and Children program and were entered into oh child's record by MHS health staff. The status of the hematocrit results were either normal ($\geq 34\%$), low ($< 33\%$) (U.S. Department of Health and Human Services, 1984). For this study it was noted if the microhematocrit data was missing or the test was not performed because the child was less than one year old.

Vision screening form: This screening was performed on site by optometry students and faculty. The vision screening form was completed by the optometry students and reviewed by faculty. The exam included acuity and strabismus testing beginning at about age three and performed every two years (U.S. Department of Health and Human Services, 1984). For this study the status of the child's screening was either pass, fail, or data missing or test not performed because the child was less than three years of age.

Enrollment form: This form contained financial, demographic, ethnic, language, education, family size, and special services information about the child's family. The form was completed at enrollment by social service staff by asking parents questions in Spanish and recording the answers in Spanish or English. For

this study the enrollment form provided information about the parent's number of years of formal education and primary language and the number of children under 18 years of age living at home in Oregon with their parents. The language was identified as Spanish or Mayan dialect or other. If the family had only one parent this also was noted.

Problem list/progress notes: Children's acute care encounters were documented by the MHS nurse practitioner at the time the child was examined for symptoms of an alteration in health. For this study one or more diagnoses for up to 8 acute care encounters were noted. The choice of diagnoses were: otitis media, respiratory infection, candida infection, gastroenteritis, conjunctivitis, dermatologic condition, and a recheck for a previously diagnosed problem and a category for other conditions not among the choices. Also noted were the total number of acute care encounters the child had with the MHS nurse practitioner during the MHS program. The nurse practitioner was on site two and one half days a week. The encounters children had during the MHS program with other medical providers were not included in the study because of the difficulty of discovering and obtaining this information.

Data Analysis

Data from the data health indicator collection form (see Appendix A) were entered into a computer for analysis. As seen on the coding sheet (see Appendix B) the majority of the data to be collected for this study were nominal. From this nominal data frequency distributions were generated for the health status indicators and socio-economic factors. Cross tabulations of selected results from health screening, physical exam and acute care encounters and socio-economic data were made. Data regarding alterations in health (as tabulated from results of health screening, physical exam, and acute care encounters) were analyzed for possible co-morbidity conditions (children with more than one alteration in health). To describe possible implications of the findings, results on relevant parameters were compared to standards from the U.S. and Oregon.

Chapter 4

Results

Results of data analysis about the younger children attending a 1993 Migrant Head Start program are presented to answer the questions about their health based on the health screening, physical exam and acute care encounters. Some of the types of health problems identified in this study were the same as some of the health problems identified by studies in the review of the literature on the health status of migrant children. Selected socioeconomic risk factors were analyzed to obtain a picture of the child's family and determine if these socioeconomic factors may be related to certain measures of health.

Sample

All 104 children between 6 months and 3 years of age on May 3, 1993, who had a physical exam at MHS during the 1993 program were included in the study. A small number of health records were missing part of the data collected for this study and this information will be noted in reporting the results. There were 49 (47%) males and 55 (53%) females in the study. Of these 104 children, 29 (28%) were six to 15 months of age, 39 (38%) were 15 months, 1 day to 24 months of age and 36 (34%) were 24 months, 1 day to 36 months of age on May 3, 1993, the first day of school.

Research question 1: Frequency of selected socio-economic factors

Most of the children in the study were born in the U.S.. Of the 97 children born in the U.S.A., 70 (71%) had Medicaid health coverage and 28 (29%) did not have Medicaid. Medicaid is the major source of payment for health care for this population of children.

Spanish was the primary language for the majority of the parents (see Table 2).

Table 2

Frequency of Primary Language for Parents of Migrant Preschool Children

Language	Parents				
	Mothers ^a		Fathers ^{a,b}		
	n	(%)	n	(%)	
Spanish	77	(75%)	70	(74%)	
Mayan Dialect	26	(25%)	25	(26%)	
	total	103	(100%)	95	(100%)

^a Data missing for 1 mother, 1 father

^b Families without father, n = 8

The number of years of education for parents ranged from 0 to 16 years. Literacy was generally assumed if a parent had 6 years or more of education. In 60% of the families, one or both parents had 6 years or more of education; conversely 40% of the families had no parent with 6 years or more education.

Almost half (49%) of the children came from families with 2 or fewer children. The mean number of children per family was 2.79 and the range was 1 to 8.

Research question 2: Frequency of abnormal and normal values on selected screening parameters

Screening for low hematocrit was performed on 76 children and of these 51 (67%) had normal results, and 25 (33%) had results which were low. Data was missing on 24 children and 3 children were too young during the program to have the screening.

Information obtained at enrollment on the health history showed that 11 of the 103 children were born premature. Data on prematurity was missing from one record.

There were 10 children out of the 104 with a condition that qualified them as disabled. These conditions included: spina bifida, speech impairment, orthopedic conditions, genetic anomalies affecting mental and physical development, and muscular

dystrophy.

Screening of growth showed that the most frequently occurring abnormal results were short stature and small head circumference (see Table 3).

Table 3

Frequency of Screening Results for Height, Weight and Head Circumference of Migrant Preschool Children

Results	Screening					
	Height		Weight		Head Circumference ^a	
	n	(%)	n	(%)	n	(%)
Normal	66	(64%)	83	(80%)	19	(48%)
Small	29	(28%)	15	(14%)	12	(30%)
Large	2	(2%)	1	(1%)	0	(0%)
Missing	7	(8%)	5	(5%)	9	(22%)
total	104	(100%)	104	(100%)	40	(100%)

^a Screening for head circumference was obtained for children under 1 year of age, n = 40

The screenings for vision, hearing and dental status (see Table 4) resulted in four children needing

vision follow-up care, 11 children needing dental care and four children needing further hearing evaluation and one child needing both vision and dental follow-up.

Table 4

Frequency of Screening Results of Vision, Hearing, and Dental Exams for Migrant Preschool Children

Results	Screening					
	Vision		Hearing		Dental	
	n	(%)	n	(%)	n	(%)
Pass	24	(83%)	67	(94%)	52	(81%)
Fail	5	(17%)	4	(6%)	12	(19%)
total	29	(100%)	71	(100%)	64	(100%)

Note. Missing data: 6 vision, 33 hearing, 5 dental

Included in the screening parameters was an evaluation of the immunization status of the children. Consistent with Oregon Health Division (1992) immunization schedule, immunization status was noted as one of the following: complete, incomplete and not up-to-date (UTD), and incomplete and up-to-date (UTD).

For the purposes of this study extra doses were noted; when computing the percent of children who were complete or incomplete but up-to-date children who had extra doses were included in those categories. There were 15 children who received extra doses of one or more vaccines than was required for their age. In Oregon three doses of Hepatitis B vaccine has been required for children born after April 15, 1992. More than half the children in this study met the age appropriate criteria for DTP, OPV, MMR, and Hib. (see Table 5).

Table 5

Frequency of Age Appropriate Immunization Rates for
Preschool Migrant Head Start Children 6 Months to 3
Years of Age

Immunization status	Immunizations			
	DTP	OPV	MMR	HIB
Complete	0	0	51	47
Incomplete not up to date	28	23	16	21
Incomplete but up to date	58	58	25	18
Extra doses	10	15	4	10
Missing data	8	8	8	8
total	104	104	104	104
Age appropriate rate ^a	65%	70%	77%	72%

^a rate = complete + incomplete but UTD + extra doses
divided by total of 104.

For the Hepatitis B immunization there were six

children who were complete for the series, eight children were incomplete and not up-to-date, three children were incomplete and up-to-date, and eight children had missing data. Their age appropriate rate was 36%. The Hepatitis B series was not appropriate for 79 children.

Rates for overimmunization ranged from 14% (n = 15) for OPV, to 10% (n = 15) for DTP and Hib, to 4% (n = 4) for MMR.

The results of the review of TB skin test status showed that 31 children tested had results that were less than 10 by 10 mm induration, three children had results of greater than 10 by 10mm induration, seven children received a TB skin test but did not return at the appropriate time to have the test read. Data were missing on 48 children and 15 children were too young to be tested.

Results from these selected screenings were similar to some of the types of health problems found in the study by Steffin and Francis (1978), such as dental caries, iron deficiency anemia, delays in immunization, otitis media, and low growth measurements. There were also similarities with the health problems found in Slesinger et al. (1986) of low immunization rates; with the health problems of anemia, respiratory infections and dental caries in Smith's et

al., (1978) study and with Dever's (1992) study which identified the health problems of respiratory infections, otitis media, eye infections, candidiasis, and anemia.

Research question 3: Frequency of selected alterations at physical exam

For 57% of the children one or more alterations were diagnosed at the physical exam (see Table 6).

Table 6

Frequency of Number of Alterations in Health for Migrant Preschool Children at Physical Exam

number of alterations	Children	
	n	%
0 alterations	45	43%
1 alteration	40	39%
2 alterations	18	17%
3 alterations	1	1%
total	104	100%

In this study the most frequently occurring alteration diagnosed at the physical exam was otitis media (see Table 7).

Table 7

Frequency of Health Alterations Diagnosed at Physical Exam for Migrant Preschool Children

Alteration	Occurrence of alteration	
	n	%
Otitis media	37	47%
Respiratory infection	16	21%
Other conditions	14	18%
Candida infection	4	5%
Conjunctivitis	3	4%
Dermatologic condition	3	4%
Gastrointestinal condition	1	1%
total alterations ^a	78	100%

^aSome children had > 1 alteration at physical exam, 78 is the total alterations

For the children diagnosed with alteration(s) in health the average number of alterations was 1.3 (number of alterations divided by the number of children with alteration(s), $78/59 = 1.3$). There were 18 children with two or more conditions diagnosed at the time of physical exam.

Acute care encounters

The acute care encounters were the visits the children made to the MHS nurse practitioner for suspected illness or health problem(s). Although 33 (32%) children did not have symptoms of illness requiring an acute care encounter visit to the nurse practitioner, 71 (68%) children had one or more encounters (see Table 8).

Table 8

Frequency of Multiple Acute Care Encounters

Children		
Number of encounters	n	%
1 encounter	13	18.0%
2 encounters	20	28.0%
3 encounters	20	28.0%
4 encounters	10	14.0%
5 encounters	6	9.0%
6 encounters	1	1.5%
7 encounters	1	1.5%
total	71	100.0%

Otitis media, conjunctivitis, and recheck for a previously diagnosed condition were the most frequently occurring conditions diagnosed (see Table 9).

Table 9

Frequency of Health Alterations Diagnosed at Acute Care Encounters for Migrant Preschool Children

Alteration	Occurrence of alteration	
	n	%
Otitis media	94	36%
Conjunctivitis	45	18%
Recheck	34	13%
Respiratory infection	26	10%
Dermatologic	21	8%
Other conditions	17	7%
Candida infection	11	4%
Gastrointestinal	11	4%
	total	259
		100%

Research question 5: Inter-relationship among results of screening, physical exam and acute care encounters

To gain a better understanding of the children's health status, the health data from the study was grouped into the above three sets and the relationship

between the sets was examined using all possible chi square combinations. The longer a child attended the program, the greater the possibility for screenings to be completed and acute care encounters to occur and these factors could potentially increase a child's score on screening and acute care encounters.

Screening Set. Information regarding prematurity, disabilities, height, weight, head circumference, hearing, vision, dental, hematocrit, immunization (DTP, OPV, MMR, Hib, Hep B) and TB skin test were grouped together as a screening set. For each child in each age group, the number of items failed was calculated as a percent of the total number of items appropriate for the age group to which the child belonged. Because the study included children of different ages, not every screening was appropriate for every child (see Appendix D) and some children missed a screening. Dental, vision, and hematocrit screening took place at various times during the summer.

The screening set percent was simply a count of failed items within the screening group. Immunization status was evaluated as of the first day of school, and immunizations which were incomplete and not up-to-date were counted as failed items. The range for the screening percent values was 0% - 67%. Of the total screening percent values 50% were 15 or less, while 50%

of the total screening percent values were 17 or greater. This high/low split information was used to perform Chi square calculations between the 3 sets of information (screening, physical exam and acute care encounters).

Alterations at physical exam set. The number of alterations diagnosed at the physical exam made up the second set of health data. At the time of the physical exam up to seven alterations in health could have been diagnosed. Every child in the study had a physical exam and 46 children had no alterations diagnosed, while 58 children had one or more alteration diagnosed. The low/high split was made between children having no alteration (44%) and children with one or more alteration (56%).

Acute care encounters set. The number of acute care encounters made up the third set of health data. Children could have 0 to 7 acute care encounters recorded. Children with 0 to 1 encounter made up 44% of the total and children with 2 to 7 encounters made up 66% of the total. The low/high split was made between children with 0 and 1 encounter and children with 2 to 7 encounters.

The three sets of health information (screening, physical exam, and acute care encounters) were cross tabulated one to the other in pairs. The chi square

test assessed statistical significance ($p = .05$). The null hypotheses that there were no relationships between sets was supported with one exception. The null hypothesis that the number of alterations on physical exam was not related to the number of acute care encounters was rejected ($X^2 = 11.82$ with 1 df, $p = .003$). That is, the number of alterations on physical exam was related to the number of acute care encounters. Moreover there did not appear to be clinical significance in the relationships.

Research question 6: Socio-economic factors and health status

To discover if socio-economic factors were related to the child's health status, four socio-economic factors were selected: parent education, parent primary language, Medicaid status, and number of children in the household. The health status factors selected were the screening, physical exam, and acute care encounter sets.

Parent education. Parent education was divided into four mutually exclusive groups. This factor combined mother and father's years of schooling to assess parent literacy (see Table 10). There were 89 families with both parents present and with complete information on education. If literacy is assumed when

one or both parents have six or more years of education, then 40% of the families had no literate parent (see Table 10).

Table 10
Education Levels of Migrant Families

Education Level	Families	
	n	%
Group 1, mom, dad < 6 years	35	39%
Group 2, mom > = 6 years, dad < 6 years	8	9%
Group 3, mom < 6 years, dad > = 6 years	14	16%
Group 4, mom, dad = > 6 years	32	36%
	total	89 100%

Note. 8 families no father, 7 families missing education level data = 15 families not included.

Medicaid status. Medicaid status was defined as child with Medicaid or child without Medicaid. There were 70 children with Medicaid and 34 children without Medicaid.

Parent language. Parent's language was divided into two mutually exclusive groups, Spanish or Mayan. In all of the families with data on parent language both the parents had the same primary language and families with the mother as head of household were included. There was one family missing data on language, and for the remaining 103 families, Spanish was their primary language for 77 (75%) and a Mayan dialect was the primary language for 26 (25%) families.

Number of children in household. The number of children residing in the home was split into two mutually exclusive groups of low and high. The low group was made up of children from families with two or less children and the high group was made up of children from families with more than two children. Each of the groups comprised 50% of the total families.

The four socio-economic factors were cross tabulated with each of the three sets of health information in pairs (total of 12 pairs). The chi square test assessed statistical significance ($p = .05$). The null hypotheses that there were no relationships between the socio-economic factors and health factor sets was supported with one exception. The null hypothesis that Medicaid status was not related to the screening set was rejected ($X^2 = 5.6$ with 1 df, $p = .017$). That is, Medicaid status was

related to the screening set. There did not appear to be clinical significance in the relationships.

Research question 7: Co-morbidities at acute care encounters

In the study there were 33 children with no acute care encounters. At the time of the acute care encounters some children were diagnosed with more than one condition. There were 38 children who had one or more encounter(s) when two or more conditions were diagnosed at the same encounter. There were a total of 196 acute care encounters and at 56 (29%) of these 196 encounters more than one condition was diagnosed.

The most frequently occurring co-morbidity was otitis media and conjunctivitis (see Table 11).

Table 11

Frequency of Co-morbidities Diagnosed at Acute Care
Encounters for Migrant Preschool Children

Co-morbidity	Occurrences	
	n	%
Otitis media + conjunctivitis	26	46%
Otitis media + respiratory inf.	5	9%
Otitis media + Respiratory inf. + conj.	4	7%
Otitis media + Candida inf.	3	5%
Otitis media + G.I.	3	5%
Respiratory inf. + G.I.	3	5%
Otitis media + dermat.	2	4%
Otitis media + dermat + G.I.	2	4%
Respiratory inf. + recheck	2	4%
Other co-morbidities occurring once each	6	11%
total	56	100%

Summary of Major Findings

Before this study was conducted none of the health and socioeconomic information for the program had been organized or analyzed. There were a variety of impressions and questions about the health status of the children. Major findings from the study provide a clearer, more accurate picture of the health status of the younger children than previously available.

Positive aspects of the health status of these young MHS children included the following: most children (94%, n = 67) passed the hearing screening; many of the children (67%, n = 51) had normal values on their hematocrit screening, the majority of the children's (80%, n = 83) weight fell within the range of normal; many children (43%, n = 45) had no alterations diagnosed at physical exam; many children (44%, n = 46) had none or one acute care encounter, and this group of migrant children's immunization rate was 65% for DTP, 70% for OPV, 77% for MMR and 72% for HIB. The study group's age appropriate combined immunization rate of 71% for DTP, OPV, and MMR was slightly better than the combined rate for DTP, OPV, MMR in children of a similar age group receiving state supplied vaccines.

Data from the socioeconomic factors showed there was a tendency toward small family size (2 children or less).

Additionally other findings from the study's socioeconomic data showed that 28 children born in the U.S.A. who should have been eligible for Medicaid did not have Medicaid insurance; that a Mayan dialect, not Spanish was the primary language for 25% of the parents (a Mayan dialect as the primary language can limit access to resources because the language is not spoken or understood by most English or Spanish speaking people); that almost 40% of the parents could be considered non-literate.

Clinical areas of concern from the health screenings for children screened were: a third (n = 25) of the children were anemic; 19%(n = 12) of the children were in need of dental treatment for pain and/or decay; 28%(n = 29) of the children were of short stature; 30%(n = 12) of the children had small head circumference; and 3 children had positive TB skin tests.

Major findings from the physical exams and acute care encounters revealed that otitis media was the most frequently diagnosed illness and that otitis media and conjunctivitis was the most frequently occurring comorbidity. There was a relationship between alteration on physical exam and the number of acute care encounters and between Medicaid status and screening results.

Chapter 5

Discussion

Meaning of the Findings

In this section findings are discussed in relation to standards, their relevance for this population and the investigator's clinical experience with this client group. There are studies from the 1970's and 1980's that identified health problems among migrant children similar to some of the problems identified in this study. No tools were found in the literature which could provide a measure of overall health status for preschool children.

Since there was an absence of patterns from the statistical tests performed on the health data, each variable for each child must be carefully monitored to determine if a child has health problems.

Socio-economic factors

For the children in this study Medicaid status appeared to be related to health status. Of the total sample of 104 children, 70 (67%) had Medicaid insurance. Of these 70 children with Medicaid 40 (57%) children had high number of alterations on screenings compared to 33% (n = 11) of the sample who did not have Medicaid. Health status is influenced by numerous variables. It is possible that parents with children

with health problems seek care for their children and as part of this process they enroll their children in Medicaid. Additional research would be needed to investigate if the relationship between Medicaid status and health screenings observed in this study occurred in other groups and if so what other significant variables might be influencing health status, other than Medicaid status. Information was not accessible to determine why 28 children born in the U.S.A. did not have Medicaid insurance.

Speaking a Mayan dialect as the primary language is neither positive or negative by itself, but speaking a Mayan dialect in a predominately English speaking society that cannot speak the dialects presents significant obstacles to securing the basic necessities of life.

Assumptions are often made that Hispanics have large families and that having a number of children is a stress on a families economic resources. The majority of the children in this study came from small families.

Screening results

When results of screening for height and low hematocrit for the children in the study were compared to the Healthy People 2000 (1989) standards the migrant children experienced more abnormalities. The Healthy

People 2000 baseline for prevalence of short stature in low-income Hispanic children age one is 16%, and the year 2000 target is 10%. The rate for the migrant children in this study was 28%. Healthy People 2000 baseline for iron deficiency in low-income children aged one to two was 21% and the year 2000 target is 10%. The rate for migrant children in this study was 33% for the children tested.

Low hematocrits and delays in growth can be influenced by families' financial resources and their knowledge of how to best use these resources to provide nourishing meals. Many migrant children are not receiving adequate nutrition to support normal growth and development, and prevent conditions such as anemia. Twenty-four hour diet recalls obtained at enrollment indicated that many children are not receiving adequate amounts of dairy products, fruits and vegetables. It is not unusual for a child to have only two meals a day.

The number of children in this study experiencing dental problems and the needing dental care represents a major health problem. Difficulties in accessing dental care for this population are significant, and represent an ongoing challenge to the MHS program. Most dentists will not examine or treat children under age three and recommend that these young children be

seen by a pediatric dentist. Finding a pediatric dentist who will accept Medicaid payment or a negotiated rate of payment and non-English speaking patients has been very difficult. Many parents of migrant children allow their children to have a baby bottle with juice or milk at night and this can promote poor dental hygiene and lead to tooth decay.

Concerns about low childhood immunization rates in the U.S. and Oregon are increasing. (Approximately 30% of the children in this study were not adequately immunized.) The age appropriate rate in Oregon for children age 2 and under in 1992 (who received state supplied vaccines for DTP, OPV and MMR) was 69% (Oregon Department of Human Resources, 1993). For this group of migrant children who were age 3 or less, the age appropriate rate for DTP, OPV, MMR was 71%. Improvement of childhood immunization rates are needed to prevent the potentially devastating effects of childhood diseases, such as the miscarriages, stillbirths and fetal anomalies that result from rubella infection during the first trimester of pregnancy (Poon, 1992).

While many children in the study did not receive a TB skin test, about 10% of the children tested (and who had their skin tests read) had a positive skin test. The county and state health departments do not maintain

statistics on the rate of positive TB skin tests, thus no comparisons can be made between the rate from this study and state statistics. A MHS program in the eastern part of the state had a positive TB skin test rate of 13% for the children tested (K. West, April 20, 1994).

These TB skin test results are clinically significant because of the implications for transmission of the disease in the migrant and general population. Positive tuberculin skin tests in children are a reflection of the disease in the adult population. Migrant children are at risk of infection because of crowded living conditions shared with foreign-born persons. Foreign-born persons make up one quarter of the cases of TB occurring in the U.S.A. (American Academy of Pediatrics, 1994). From 1985 to 1991 there was a 19% increase in cases of TB among 0 - 4 year olds and a 40% increase among children in the 5 -14 year old age group (Jackson, M., 1993). The problems of access to health care and understanding of the disease, as well as frequent change of residence contribute to the problems of follow-up treatment compliance for positive TB skin tests.

Illness

Considering that otitis media was the most frequently diagnosed illness at physical exams and

acute care encounters, this illness was present in a significant part of the migrant child population all the time.

Of the four children who failed the hearing screening, two children had one episode of otitis media documented in the MHS health record and two children had no episodes of otitis media documented in the school health record.

Because alteration(s) diagnosed at physical exam and acute care encounter(s) were related, children with diagnosed alterations in health at one point in the program probably could be expected to have had another illness during the program.

Limitations

Children selected for this study came from families who applied to the MHS program, met program criteria for migrant status and income and thus may not represent all migrant children. Results from this study were based on information that was available in the child's health record. Additionally, children included in the study must have had a physical exam during the MHS program, so children without a physical exam were excluded from the study; their health data was not evaluated or included. Children attending the program for a longer length of time (i.e., six months rather than six weeks) would potentially have more

health data in their records. Another possible limitation of the study was the reliability of the performance and documentation skills of MHS personnel involved in screenings such as height, weight and head circumference and gross hearing.

This study did not include information about children's health care encounters at other health agencies while enrolled in the MHS program, so a total picture of health status may not have been presented and the nature and extent of problems for some children may be understated. Data was from the summer months, a time when many people believe children are generally in better health than during the winter months.

Specific results from this study can be generalized to the preschool migrant population in the geographic area served by this MHS program. Generally the types of health problems seen among the migrant children seen in this study would most likely be similar for other migrant groups in the state and the western stream. From informal discussion with other MHS programs in the state, children at other locations also experience health problems that include anemia, short stature, inadequate immunization, positive TB skin tests, tooth decay, otitis media and conjunctivitis.

The data for this study was the best data

available for analysis to answer questions about the health status of a group of young migrant children attending MHS about whose health status very little had been known prior to this study. Results from this study should not be generalized to other migrant streams (eastern and midwest).

Implications for practice

Implications for practice are presented from the perspective of access to health care, health maintenance, and treatment issues with selected references to Leininger's Sunrise Model. The topic of program management is briefly discussed as a separate though related issue to the implications for practice. Suggestions for subsequent research related to the health status of migrant children are identified.

Access to health care

Access to health care in the U.S. depends for the most part one's ability to pay for the care. Migrant health clinics offer basic health care to the migrant population with Medicaid and Medicare insurance or accept a sliding scale payment schedule. A source of health care insurance for many migrant children is the Medicaid insurance. Children born in the U.S., whose families meet the Medicaid income criteria are eligible for Medicaid. The reason for families with children

born in the U.S.A. and eligible for MHS not having Medicaid insurance was not known. Automatic access to health care services for clients with Medicaid is not guaranteed because some health care providers do not accept Medicaid patients.

Enactment of The Oregon Health Plan (OHP), February 1, 1994 appears to have increased the complexity of applying for Medicaid in Oregon. Under The Oregon Health Plan there are many choices of plans and under each plan there is a choice of many providers. The process of application and enrollment has become more complicated and the plan has experienced heavier subscription than anticipated. As in previous years, migrant families moving between states must reapply for Medicaid in each state.

The Medicaid status of every child enrolled in MHS should be obtained at the time of enrollment. Resources should be identified and/or developed to assist families in applying for Medicaid. While some families come to Oregon for short periods of time, these families should also be encouraged to apply for Medicaid for their U.S. born children because under The OHP insurance coverage can be retroactive to the date the family formally requested application. Medicaid insurance may help reduce the problems of access to dental care because there are dental plans under the

OHP, however to-date little improvement in access to dental care for children has occurred. If families obtain coverage for their eligible children, Medicaid should pay for most of the health screening, immunizations, diagnosis and treatment, and limited MHS funds can be directed toward the care of children who do not qualify for Medicaid.

Since a number of families have one or more Mayan dialects as their primary language and have limited use of Spanish it is important the MHS program identify members of the migrant community who can facilitate communication between these parents and the program. Access to health care for people who speak Spanish is difficult, for Mayan speaking families access can be nearly impossible.

It is equally important that Spanish speaking families be involved in the program. Use of health promoters is one method which has been implemented on a very limited scale, but appears beneficial way to reach out and assist families. Often health promoters are people from the migrant community who have knowledge of the cultures, beliefs and practices of the populations being served as well as the MHS program. They work to bring the population and program together to improve the health status of the participants. It is important for all MHS staff to understand and respect the

cultural differences among the populations they serve. Leininger's (1985) concept of culture care maintenance should become part of the interaction with families. Culture care maintenance occurs when culturally based assistive, facilitative or enabling events help individuals to preserve or maintain favorable health and lifeways.

Health maintenance

Communication with parents of the children participating in the MHS program is critically important to the maintenance of health for the children. Communicating with non-literate parents presents many special problems and challenges. Ways of enhancing communication include involvement of parents in their children's school activities whenever possible; use of drawings to communicate information; and use of health promoters to visit parents in the evening at home. Information should be easily accessible to staff regarding the most appropriate way to communicate with a family considering their literacy level and primary language. Opportunities for parents to share and clarify their values on health and education should provide the program with valuable insight about working with the families. Ongoing training and sharing of ideas among staff, as well as staff and parents can help overcome the barriers to

effective communication.

Parent education promoting the prevention of health problems is an important function of the MHS program. Educational programs and individual guidance are activities that can help parents learn about managing the health of their families. Also the staff can learn from the Mexican and Guatemalan families how they have cared for themselves for centuries with limited reliance on the medical model. As Leininger notes, we have the responsibility help families of various cultures maintain the practices they value which contribute to their life and health.

Because immunization rates for this group of migrant children need to be increased, parents should be encouraged and supported to maintain their children's immunizations up-to-date. Parents should be requested to have their child's immunizations up-dated before school starts. Resources for immunization and transportation to clinics should be provided to parents. Evening immunization clinics held at the MHS school sites would provide services at times when parents are not working and can be involved in the maintenance of their children's health.

Treatment issues

Problems of failed screening(s) and abnormal conditions discovered at physical exam need to be

identified as early as possible in the program to allow for follow-up evaluation and treatment. While at present the screenings are not performed at the time of enrollment, health fairs conducted before the first day of school can be planned to provide some of these screenings. Fairs should be conducted at times that are convenient for migrant families and in locations that are easy to find. Information about the fairs needs to be communicated in a manner that considers the parents literacy level and their primary language. Physical exams need to be conducted as soon as possible after school begins to allow time for follow-up while the child is still attending the program.

Since otitis media was the most frequently diagnosed illness for these migrant children, resources should be identified and developed to minimize its negative impact on the health of the children and stress on families and the MHS program.

The following activities could form the basis for a plan to provide improved management of this illness:

1. Identification of children at enrollment with a history of otitis media as children at risk for repeated episodes of the illness.

2. If otitis media is identified at physical exam or acute care encounter, assist parents to comply with treatment and recheck instructions.

3. Share data from this study with school nurse practitioner to increase awareness of the significance of otitis media in this population.

4. Open a discussion with parents on their perspective of this condition. Is it a concern and do they want assistance managing the illness?

5. Develop and implement a program of parent and classroom teacher education on otitis media based on parent input and to include information on:

- a. prevention (i.e., feeding issues),
- b. signs and symptoms of illness,
- c. medication administration/compliance,
- d. communicating with your health provider,
- e. importance of rechecks after otitis media,
- f. treatment options for chronic otitis media.

6. Identification of referral resources and referral guidelines.

7. Develop a plan to case manage children with chronic otitis media.

Program management issues

Staff involved in the screenings need to be well trained for the responsibilities they will assume. An inaccurately performed screening can negatively impact the health status of a child and waste limited health care resources.

Periodic re-evaluation of minimal screening standards are necessary to insure the highest quality of care possible is offered to the children.

Cooperative agreements with agencies providing needed services such as immunization, TB follow-up, vision screening, physical exams, dental screening, and other services should be established.

Data on rates of positive TB skin tests should be documented by MHS programs in Oregon and shared with the Oregon Health Division to help establish a baseline for this important screen.

At present there are a total of 8 Migrant Head Start Programs in Oregon. All of the programs including the program in this study are operated by the same grantee. Data from this program could be compared to same data collected by the other MHS programs in the state to develop a baseline on the health status of the children enrolled.

Information from this study should be used to focus program resources on the health needs of the population. Additionally information from this study could be shared with parent groups and as the MHS program works with parents to improve the health status of those children with less than optimum health and to maintain the health status of the children in good health.

Implications for research

There are implications for research subsequent to this study. Additional studies are needed to expand the type and amount of information on the health of migrant children. Studies combining the same type of data from all 8 MHS programs in the state could form a baseline of information for the grantee to measure change in the population health status and program effectiveness. This study included children from six months to three years of age, but information on all age groups attending MHS are needed to obtain a better understanding of the health status of this population. Studies of this population conducted over time could show changes in the population and their health needs and health status.

Further studies are needed to help determine the effectiveness of the program in identifying health needs and providing or accessing appropriate and timely follow-up. For example, specific studies are needed on the immunization status of the children at the beginning of the program and when they leave the program to determine impact of the MHS program is on this health need. More information is need about the reasons for families with children born in the U.S. not having Medicaid insurance.

To assist in evaluating the effectiveness of MHS

program studies are needed to evaluate the childrens' health status as they enter the program compared to their status when they leave the program.

Studies which focus on specific health problems such as otitis media and dental decay could provide information on incidence, and treatment to be used for program planning and health promotion.

Qualitative studies are needed to conceptualize migrant parents perspectives on health status, need for treatment of health problems and barriers to obtaining care deemed to be important. Very little is known or documented about how migrant parents feel about the MHS program and if from their perspective the program meets the their childrens health needs.

Conclusion

Migrant children come from families that experience many hardships. The basic needs of life, food, housing, safety and health can not be assumed by this population. The Migrant Head Start Program provides migrant children the opportunity to be prepared for learning. To be able to benefit from the learning environment children need to be in good health.

This study of the health status of a group of young children attending a MHS program was initiated to

provide the program with a clearer picture of the children's health assets and needs. The literature has a very limited number of studies on this population.

Before appropriate programs of health promotion and intervention can be designed for groups there should be a set of basic information on the population. This study provides information on the types of health problems migrant children experience as well as the frequency of these problems. This study provides a baseline for monitoring changes in the health status of the population over time. Information from this study can assist the program to determine if services provided are the services needed and what program changes would help improve the health status of the children.

Results of this study can be shared with health care agencies such as the county health department and local migrant health clinic which provide much of the health care to migrant families. Study information could be used in and for the basis of grant applications and cost projections for health services such as needed nurse practitioner hours or follow-up health care services.

Information from this study on the migrant family can increase the program's understanding of parent educational level, family size and primary language,

thus allowing for potentially improved working relationship with the families. The ultimate goal of MHS serving migrant families is to facilitate their empowerment, so that they will be able to better provide for their own and their children's needs in the years to come.

At a critical time of change in health care for the state with the initiation of a new health plan, it is important for health providers to know more about the health status of the populations they are responsible for serving. The MHS program must be able to coordinate services for the children with health plans from a position of knowledge about what the population needs.

Head Start Programs were developed by North Americans for a North American population. Migrant Head Start Programs represent an implementation of the Head Start Program concept for a population that is distinctly different in terms of culture, values, education, language, beliefs, social and kinship structure from the population originally intended for the program. Leininger's Sunrise Model provides a basis for pressing to further understand the relationship and influence of social structure and world view on care and health in individuals, families, cultural groups into care in health systems. The

meaning of health, wellness, illness like most aspects of life are defined by each culture. Some meanings are universally shared while others are specific to the group. By identifying the differences and similarities of health care between North Americans and people from Mexico and Guatemala it will be possible to establish a basis for nursing knowledge that can be used to guide nursing care decisions that are beneficial to families and their children.

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APPENDIX A

ENCOUNTERS

ID #

1

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

2

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

3

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

4

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

5

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

6

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

7

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

8

RI CI GI COM DR AC O OM RI CI GI COM DR AC O OM

ENC

APPENDIX B

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Created: 03-18-1994
 Modified: 03-18-1994
 Sort Variables: None

Vars: 99
 Obs: 0

Bytes: 3960

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	2	DOBMO	MONTH OF BIRTH	2	0	N	0
	3	DOBDAY	DAY OF BIRTH	2	0	N	0
	4	DOBYEAR	YEAR OF BIRTH	2	0	N	0
	5	GENDER	GENDER	2	0	N	2
		1	MALE				
		2	FEMALE				
	6	PREM	PREMATURE	2	0	N	3
		0	NOT PREMATURE				
		1	PREMATURE				
		2	MISSING DATA				
	7	PLBIRTH	PLACE OF BIRTH	2	0	N	3
		* 0	USA				
		1	NOT USA				
		2	MISSING DATA				
	8	MEDICAID	MEDICAID STATUS	2	0	N	3
		0	HAVE MEDICAID				
		* 1	DO NOT HAVE MEDICAID				
		2	MISSING DATA				
	9	HEIGHT	HEIGHT	2	0	N	4
		0	NORMAL				
		1	SMALL				
		2	LARGE				
		3	MISSING DATA				
	10	WEIGHT	WEIGHT	2	0	N	4
		0	NORMAL				
		1	SMALL				
		2	LARGE				
		3	MISSING DATA				
	11	HEADCIR	HEAD CIRCUMFERENCE	2	0	N	4
		0	NORMAL				
		1	SMALL				
		2	LARGE				
		3	MISSING DATA				
	12	DENTAL	DENTAL STATUS	2	0	N	5
		0	NO DEANTAL PROBLEMS				
		1	PAIN AND DECAY				
		2	DECAY AND PROBLEMS				
		3	MISSING DATA				
		4	NOT APPLICABLE				
	13	DISAB	DISABILITIES	2	0	N	3
		0	NO DISABILITIES				
		1	DISABILITIES				
		2	EVALUATION				
	14	DTP	DTP	2	0	N	5
		0	COMPLETE				
		1	INC NOT UTD				
		2	INC UTD				
		3	EXTRA DOSES				

FILTER: None

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			2 INC UTD				
			3 EXTRA DOSES				
			4 MISSING DATA				
	16	MMR	MMR	2	0	N	5
			0 COMPLETE				
			1 INC NOT UTD				
			2 INC UTD				
			3 EXTRA DOSES				
			4 MISSING DATA				
	17	HIB	HIB	2	0	N	5
			0 COMPLETE				
			1 INC NOT UTD				
			2 INC UTD				
			3 EXTRA DOSES				
			4 MISSING DATA				
	18	HEPB	HEPB	2	0	N	5
			0 COMPLETE				
			1 INC NOT UTD				
			2 INC UTD				
			3 EXTRA DOSES				
			4 MISSING DATA				
	19	TB	TB	2	0	N	5
			0 <10X10 INDURATION				
			1 >10X10 INDURATION				
			2 GIVEN NOT READ				
			3 MISSING DATA				
			4 NOT APPLICABLE				
	20	HCT	HCT	2	0	N	4
			0 NORMAL				
			1 LOW				
			2 MISSING DATA				
			3 NOT APPLICABLE				
	21	OM	OM	2	0	N	3
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			1 DIAGNOSED				
			2 MISSING DATA				
	22	RI	RI	2	0	N	3
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
			2 MISSING DATA				
	23	CI	CI	2	0	N	3
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			1 DIAGNOSED				
			2 MISSING DATA				
	24	GI	GI	2	0	N	3
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			1 DIAGNOSED				
			2 MISSING DATA				

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	26	DERM	DERM	2	0	N	3
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			1 DIAGNOSED				
			2 MISSING DATA				
	27	OTHERCON	OTHER CONDITION	2	0	N	3
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
			2 MISSING DATA				
	28	VISION	VISION	2	0	N	4
			0 PASS				
			1 FAIL				
			2 MISSING DATA				
			3 NOT APPLICABLE				
	29	HEARING	HEARING	2	0	N	4
			0 PASS				
			1 FAIL				
			2 MISSING DATA				
			3 NOT APPLICABLE				
	30	MOMED	MOTHER'S EDUCATION	2	0	N	0
	31	DADED	FATHER'S EDUCATION	2	0	N	0
	32	MOMLANG	MOTHER'S PRIMARY LANGUAGE	2	0	N	4
			0 SPANISH				
			1 MAYAN DIALECT				
			2 OTHER LANGUAGE				
			3 MISSING DATA				
	33	DADLANG	FATHER'S PRIMARY LANGUAGE	2	0	N	4
			0 SPANISH				
			1 MAYAN DIALECT				
			2 OTHER LANGUAGE				
			3 MISSING DATA				
	34	NUMCHILD	NUMBER_OF CHILDREN	2	0	N	0
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			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	36	RI1	RI1	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	37	CI1	CI1	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	38	GI1	GI1	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	39	CONJ1	CONJ1	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	40	DERM1	DERM1	2	0	N	2
			0 NOT DIAGNOSED				

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			1 DIAGNOSED				
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			1 DIAGNOSED				
	43	OM2	OM2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	44	RI2	RI2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	45	CI2	CI2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	46	GI2	GI2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	47	CONJ2	CONJ2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	48	DERM2	DERM2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	49	RECK2	RECK2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	50	OTHER2	OTHER2	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	51	OM3	OM3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	52	RI3	RI3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	53	CI3	CI3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	54	GI3	GI3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	55	CONJ3	CONJ3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	56	DERM3	DERM3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				
	57	RECK3	RECK3	2	0	N	2
			0 NOT DIAGNOSED				
			1 DIAGNOSED				

FILTER: None

File Pos	Name	Label	Field Width	Prt Fmt	Type	Value Labels
58	OTHER3	OTHER3	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
59	OM4	OM4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
60	RI4	RI4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
61	CI4	CI4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
62	GI4	GI4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
63	CONJ4	CONJ4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
64	DERM4	DERM4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
65	RECK4	RECK4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
66	OTHER4	OTHER4	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
67	OM5	OM5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
68	RI5	RI5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
69	CI5	CI5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
70	GI5	GI5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
71	CONJ5	CONJ5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
72	DERM5	DERM5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
73	RECK5	RECK5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
74	OTHER5	OTHER5	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				

FILTER: None

File Pos	Name	Label	Field Width	Prt Fmt	Type	Value Labels
75	OM6	OM6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
76	RI6	RI6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
77	CI6	CI6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
78	GI6	GI6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
79	CONJ6	CONJ6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
80	DERM6	DERM6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
81	RECK6	RECK6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
82	OTHER6	OTHER6	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
83	OM7	OM7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
84	RI7	RI7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
85	CI7	CI7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
86	GI7	GI7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
87	CONJ7	CONJ7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
88	DERM7	DERM7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
89	RECK7	RECK7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
90	OTHER7	OTHER7	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
91	OM8	OM8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				

FILTER: None

File			Field	Prt		Value
Pos	Name	Label	Width	Fmt	Type	Labels
92	RI8	RI8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
93	CI8	CI8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
94	GI8	GI8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
95	CONJ8	CONJ8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
96	DERM8	DERM8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
97	RECK8	RECK8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
98	OTHER8	OTHER8	2	0	N	2
		0 NOT DIAGNOSED				
		1 DIAGNOSED				
99	NUMENC	NUMBER OF ENCOUNTERS	2	0	N	0

APPENDIX C

MIC

MIGRANT & INDIAN COALITION
FOR COORDINATED CHILDCARE INC.

P. O. BOX 203
WOODBURN, OR 97071

(503) 981-0135 • FAX (503) 981-0176

Date _____

Person filling out this form _____

Center _____

CHILD HEALTH HISTORY FORM

(SHOULD BE ATTACHED TO EMERGENCY MEDICAL CARD)

1. Child's Name _____
LAST FIRST MIDDLE

Birth Date: _____ Gender _____

2. Person Interviewed _____

Relationship to child _____

HEALTH

3. When was the child last seen by a doctor and for what? _____

4. What was the name and address of clinic or doctor? _____

5. Where was child born? _____
(CITY/STATE) (COUNTRY) (NAME OF HOSPITAL)

6. Has the child ever been hospitalized (other than birth)? _____
(Give date, name and location of hospital, doctor, and diagnosis, if possible) _____

7. Is this child taking any medication now? Yes No
(If yes, what, how much and for how long) _____

DEVELOPMENTAL

(The following questions are personal questions we need to ask in order to have a clear picture of your child's health and developmental status. All responses are kept confidential).

1. Was this child born early? Yes No
(If yes, how many weeks early) _____

2. What was the child's birth weight? _____

3. Did you take any medication during this pregnancy? Yes No
(If yes, what medication) _____

4. Did you drink alcohol during this pregnancy? Yes No
(If yes, how much?) _____

5. Did you smoke cigarettes during this pregnancy? Yes No
(If yes, how much?) _____

6. Did this baby have any problems during the first two weeks of life? Yes No
(If yes, please describe) _____

7. Did this baby go home from the hospital with his/her mother? Yes No
(If no, give reason) _____

8. When did your child start walking? _____

9. When did your child sit up? _____

10. Does your child talk? Yes No What words? _____

11. How does your child communicate with you? _____

12. What kind of help will this child need in the bathroom?
(Is she/he still in diapers?) Yes No _____

MEDICO ALERTA

CENTRO DE PADRES E HIJOS DE HILLSBORO
EN CASOS DE EMERGENCIA

ALERGIAS _____

Entry Date _____

Nombre del Padre _____ Fecha de Nacimiento _____
(Apellido)

Nombre de la Madre _____ Fecha de Nacimiento _____
(Apellido)

Nombre del Alumno _____ Fecha de Nacimiento _____
(Apellido)

Dirección _____ Teléfono _____

Número de Tarjeta Médica _____ Nombre y Número de Seguro Médico _____

Localize al padre en _____ Teléfono _____
(Lugar de empleo)

Localize a la madre en _____ Teléfono _____
(Lugar de empleo)

Family Physician _____ Teléfono _____

Si su cónyuge no se pueden localizar en caso de una enfermedad no seria, comuníquese con pariente, vecino, amigo:

(Nombre) (Dirección) (Teléfono)

En caso de un accidente ó una emergencia, yo autorizo a un empleado de la programa Centro de Padres E Hijos de para que lleve a mi al médico arriba mencionado, ó a cualquier otro médico, ó a la sala de emergencia del hospital mas cercano para que se le proporcione el tratamiento de emergencia que sea requerido para seguridad y protección de mi. Yo seré responsable de los gastos.

Firma _____
(Padre ó Guardián) (Fecha)

Problemas de salud crónico (dental, de la vista, oídos, enfermedades)

¿Ha estado hospitalizado durante los últimos 12 meses? _____ ¿Porque razón? _____

¿Toma alguna medicina? _____ ¿Si, qué medicina? _____

¿Tiene problemas de alergias? (ronchas, picazón, hinchazón, dificultad de respirar, estornudos?)

A) ¿Cuando como ciertos alimentos? _____

B) ¿Cuando toma alguna mediciana? _____

C) ¿Cuando esta cera de animales, pieles, insectos, polvo etc.? _____

¿Adonde va usted para su embarazo? _____

¿Que es la fecha de nacimiento? _____

W I C

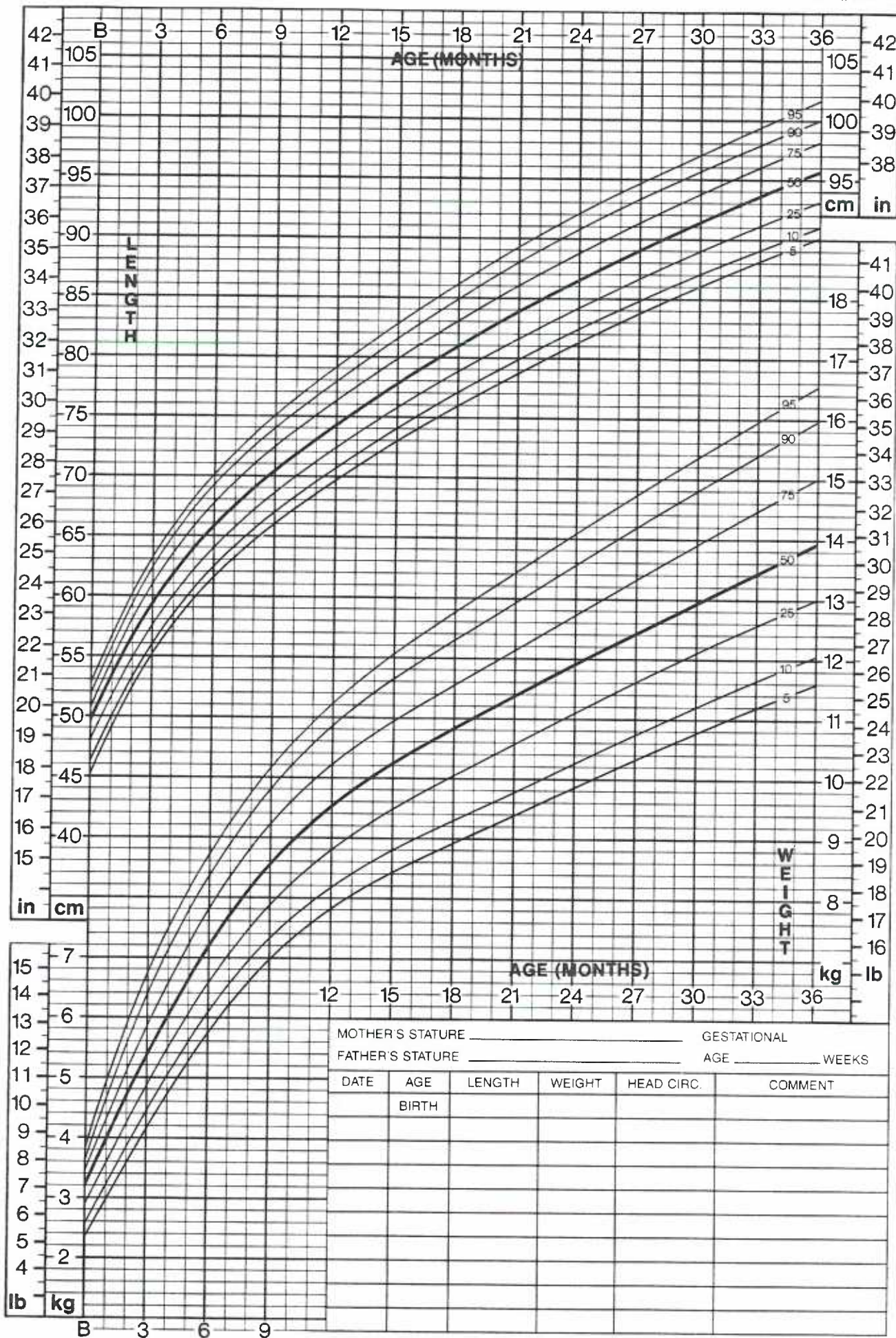
GIRLS: BIRTH TO 36 MONTHS PHYSICAL GROWTH NCHS PERCENTILES*

NAME _____

RECORD # _____



Ross
Growth &
Development
Program

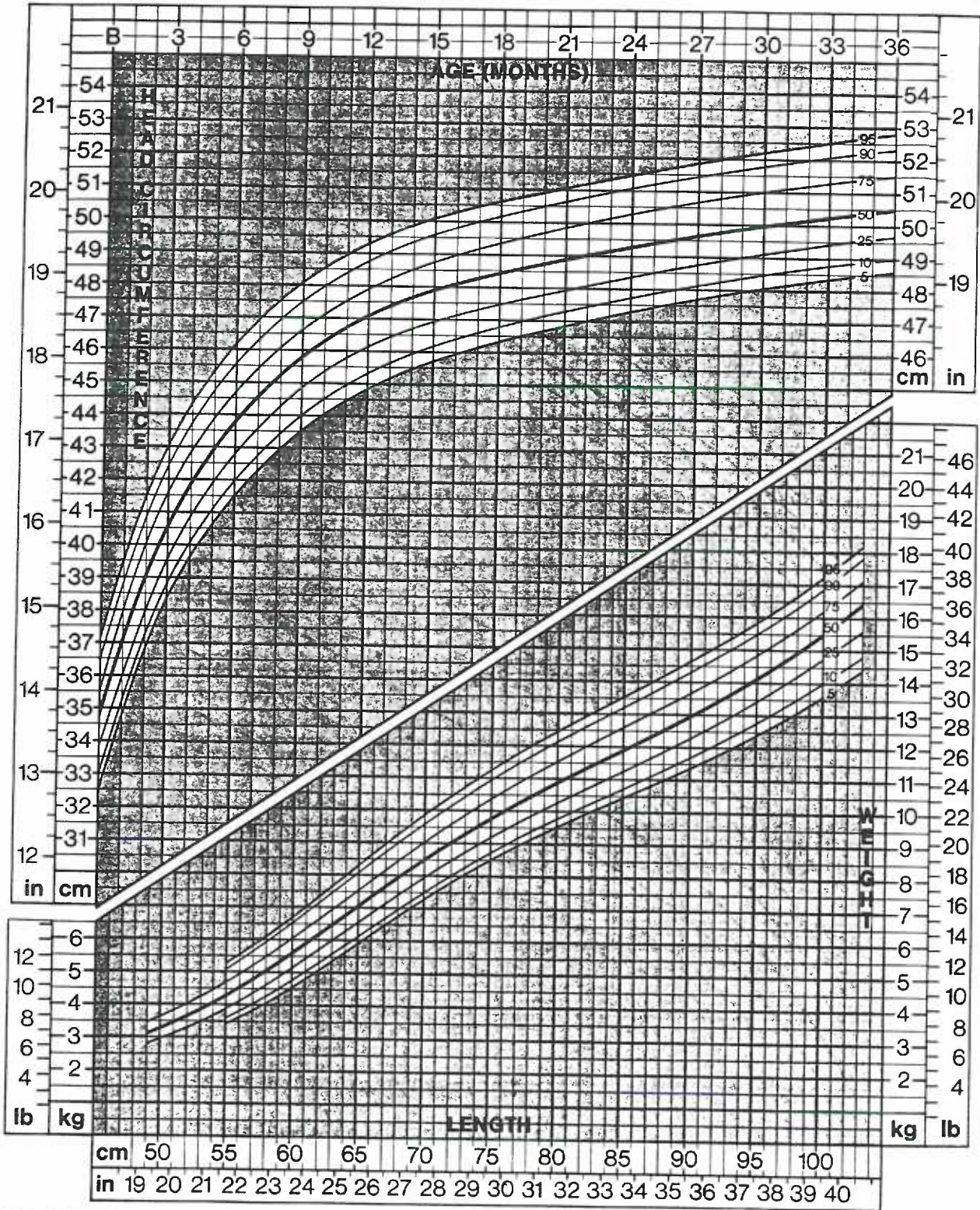


* Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Longitudinal Study. Wright State University School of Medicine, Yellow Springs, Ohio.

**BOYS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES***

NAME _____

RECORD # _____



* Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Longitudinal Study, Wright State University School of Medicine, Yellow Springs, Ohio.

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DATE	AGE	LENGTH	WEIGHT	HEAD CIRC.	COMMENT

SIMILAC* WITH IRON Infant Formula
First choice of more physicians
and used in more hospitals

ISOMIL* Soy Formula With Iron
First choice of more physicians
for milk-free feeding

ROSS LABORATORIES
COLUMBUS, OHIO 43216
Division of Abbott Laboratories, USA

51208 09890WB

U740 IN USA

MIGRANT HEAD START

Contents of Disabilities File

To be attached to inside of file of child identified as having a disability.

Record Date
Placed in File

- | | |
|-------|---|
| _____ | 1. First Referral Form |
| _____ | 2. Copy of developmental screening; ESI / Denver II |
| _____ | 3. Vision screening results (Health file) |
| _____ | 4. Hearing screening results (Health file) |
| _____ | 5. Health history (Health file) |
| _____ | 6. Previous medical reports sent for, when indicated |
| _____ | 7. Parent consent form for diagnostic evaluation (signed & dated) |
| _____ | 8. Parental Rights and Due Process Form (signed) when indicated (in Spanish) |
| _____ | 9. Diagnostic Reporting and Referral Form |
| _____ | 10. Teacher Observation Forms |
| _____ | 11. Team Meeting Reports |
| _____ | 12. Parent I.F.S.P. Meeting Notification |
| _____ | 13. I.F.S.P./I.E.P. signed by parents |
| _____ | 14. Disabilities Classroom Work Plans, copies |
| _____ | 15. Diagnostic Reports and Observations from mental health, speech, nutrition, etc. when indicated (multi-disciplinary diagnostic team) |
| _____ | 16. Change of Placement (If necessary) |
| _____ | 17. I.E.P./I.F.S.P. Monthly Updates |
| _____ | 18. Miscellaneous correspondence relating to child |

CERTIFICATE OF IMMUNIZATION STATUS

THE OFFICIAL DOCUMENT FOR VERIFYING VACCINE PROTECTION

FOR SCHOOL, DAYCARE & PRESCHOOL ATTENDANCE

OREGON DEPARTMENT OF HUMAN RESOURCES



SCHOOL OR FACILITY USE ONLY

SCHOOL _____

STUDENT I.D. # _____

SCHEDULE #1 #2
 MEDICAL EXEMPTION

PERMANENT DATE _____

TEMPORARY REVIEW DATE _____

INSTRUCTIONS

TO ATTEND AN OREGON SCHOOL, DAYCARE OR PRESCHOOL, PROOF OF IMMUNIZATION MUST BE PROVIDED OR A PROPERLY DOCUMENTED RELIGIOUS OR MEDICAL EXEMPTION SIGNED. THE VACCINE HISTORY MUST INCLUDE THE MONTH AND YEAR IN WHICH EACH DOSE WAS RECEIVED. NEW DOSE INFORMATION MUST BE ENTERED INTO THIS DOCUMENT, INITIALED AT ENTRY & DATED AND RE-SIGNED AT THE BOTTOM OF FORM BY PARENT, GUARDIAN OR HEALTH PRACTITIONER. OTHER ACCEPTABLE METHODS FOR UPDATING RECORDS ARE EXPLAINED IN THE IMMUNIZATION HANDBOOK. PLEASE CIRCLE THE TYPE OF VACCINE RECEIVED. FOR FURTHER INFORMATION CONSULT YOUR SCHOOL, DAYCARE OR PRESCHOOL ADMINISTRATOR OR DESIGNEE.

THE STUDENT

COUNTRY OF BIRTH _____

LAST NAME _____ FIRST _____ M.I. _____ SEX _____ BIRTHDATE (MO/DAY/YR) _____

MAILING ADDRESS _____ CITY _____ COUNTY _____ ZIP _____

LAST SCHOOL, DAYCARE, OR PRESCHOOL ATTENDED _____ TELEPHONE _____

THE PARENT OR GUARDIAN

NAME _____ TELEPHONE (WORK) _____ (HOME) _____

SECTION A

VACCINE HISTORY

VACCINE	DOSE	MO.	DAY	YR	INITIAL	DATE
DTP/DT/Td	1					
	2					
	3					
	4					
	5					
	6					
TOPV / I PV	1					
	2					
	3					
	4					
	5					
MEASLES	1					
	2					
RUBELLA	1					
	2					
MUMPS	1					
	2					
HAEMOPHILUS INFLUENZAE b HbOC / PRP-OMP / PRP-D / HbPV	1					
	2					
	3					
	4					

SECTION B

MEDICAL EXEMPTION

I CERTIFY THAT THE ABOVE NAMED STUDENT SHOULD BE EXEMPTED FROM THE REQUIREMENTS FOR THE FOLLOWING VACCINES:

- DIPHTHERIA MEASLES HAEMOPHILUS b
 TETANUS RUBELLA POLIO
 BASED ON: MUMPS

- HISTORY OF DISEASE (MO/YR) _____
 THE FOLLOWING REASON WHICH CONSTITUTES A MEDICAL CONTRAINDICATION IN ACCORDANCE WITH THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE U.S. PUBLIC HEALTH SERVICE FOR THE VACCINE(S) INDICATED: _____

PHYSICIAN OR COUNTY HEALTH DEPT. (PLEASE PRINT) PHONE _____

SIGNATURE-PHYSICIAN OR COUNTY HEALTH DEPT. DATE _____
 (M.D. N.D. D.O. R.N.)

SECTION C

RELIGIOUS EXEMPTION

I HAVE READ AND UNDERSTAND THE INFORMATION ON THE REVERSE SIDE OF THIS FORM. MY CHILD IS BEING RAISED AS AN ADHERENT TO A RELIGION THE TEACHINGS OF WHICH ARE OPPOSED TO IMMUNIZATION AND I REQUEST THAT MY CHILD THEREFORE BE EXEMPTED FROM IMMUNIZATION REQUIREMENTS.

SIGNATURE OF PARENT OR GUARDIAN DATE _____

SIGNATURES OF VERIFICATION

PLEASE CHECK APPROPRIATE BOX BELOW:

PARENT OR GUARDIAN OR HEALTH CARE PRACTITIONER _____ DATE _____

PARENT/GUARDIAN HEALTH CARE PRACTITIONER

UPDATE SIGNATURE #1 _____ DATE _____

PARENT/GUARDIAN HEALTH CARE PRACTITIONER

UPDATE SIGNATURE #2 _____ DATE _____

PARENT/GUARDIAN HEALTH CARE PRACTITIONER

UPDATE SIGNATURE #3 _____ DATE _____

PARENT/GUARDIAN HEALTH CARE PRACTITIONER

COMPLETE FOR ALL (PINK)
 UP-TO-DATE (GOLD)
 MEDICAL (PURPLE)
 RELIGIOUS (BLUE)
 DATES DOSES NEEDED (YELLOW)
 DTP/DT/Td #1 #2 #3 #4 #5 (BLACK)
 POLIO #1 #2 #3 #4 (RED)
 MMR (GREEN)
 HbOC PRP-OMP HbPV (GREEN)
 #1 #2 #3 #4

CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____

1. RELEVANT INFORMATION (from Health History, Parent/Teacher Observations):

2. SCREENING TESTS. Starred Items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a. PRESENT AGE*		____ Yrs., ____ Mos.	g. VISION (Type of Test)*		
b. HEIGHT (no shoes, to nearest 1/8 in.)*			ACUITY, R/L _____		
c. WEIGHT (light clothing to nearest 1/4 lb.)*			RESCREENING _____		
d. BLOOD PRESSURE			STRABISMUS _____		
e. HEMATOCRIT or HEMOGLOBIN*			COMMENTS _____		
f. HEARING (Type of Test)*			h. OTHER TESTS (if indicated)		
RESULTS, R/L _____			(1) TB _____		
RESCREENING _____			(2) Sickie Cell _____		
COMMENTS _____			(3) Lead _____		
			(4) Ova & Parasites _____		
			(5) Urinalysis _____		
			(6) Other _____		

PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

3. PHYSICAL EXAMINATION/ASSESSMENT. Complete and return top three copies to Head Start.

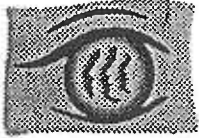
	NORMAL FOR AGE	ABNOR. MAL	NOT EVAL.	COMMENTS (Use Additional sheet if necessary)
a. GENERAL APPEARANCE				
b. POSTURE, GAIT				
c. SPEECH				
d. HEAD				
e. SKIN				
f. EYES: (1) External Aspects				
(2) Optic Fundscopic				
(3) Cover Test				
g. EARS: (1) External & Canals				
(2) Tympanic Membranes				
h. NOSE, MOUTH, PHARYNX				
i. TEETH				
j. HEART				
k. LUNGS				
l. ABDOMEN (include hernia)				
m. GENITALIA				
n. BONES, JOINTS, MUSCLES				
o. NEUROLOGICAL/SOCIAL				
(1) Gross Motor _____				
(2) Fine Motor _____				
(3) Communication Skills _____				
(4) Cognitive _____				
(5) Self-Help Skills _____				
(6) Social Skills _____				
p. GLANDS (Lymphatic/Thyroid)				
q. MUSCULAR COORDINATION				
r. OTHER				

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature: _____ Date: _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS <i>(Initial when complete)</i>	DATE
a			
b			
c			
d			



**PACIFIC UNIVERSITY
COLLEGE OF OPTOMETRY
FAMILY VISION CENTERS**

Name _____ Age _____ Grade _____ Birthdate _____ Date _____

Address _____ Telephone _____

The above named person was included in a recent vision screening conducted by _____ in cooperation with Pacific University College of Optometry. The result of the screening and the appropriate recommendations are listed below. The screening evaluated eye health and those visual skills which are considered by authorities in vision to be necessary for efficient, comfortable seeing. Failure to meet any one of them indicates a need for further evaluation. The screening is not, however, a complete visual case study, nor does passing guarantee that an individual is free from visual deficiencies.

The person who passes is not likely to be in need of visual care and the one who fails it is likely to need care. Additionally, because vision changes can occur quite rapidly, a person's visual status should be evaluated at least yearly.

Note to intern: Please make person or accompanying responsible individual aware of this:

The information on this form may be shared with the screening sponsor unless you indicate otherwise by initialing here _____

Significant History: _____

Rx Worn: Far/ Near

Has the person ever had an eye exam?

If so, who was the doctor (M.D./O.D.)?

Criteria Met	Criteria Not Met
Visual Acuity	
<input type="checkbox"/> Far OD 20/ _____	<input type="checkbox"/>
<input type="checkbox"/> OS 20/ _____	<input type="checkbox"/>
<input type="checkbox"/> Near OD 20/ _____	<input type="checkbox"/>
<input type="checkbox"/> OS 20/ _____	<input type="checkbox"/>
Cover Test	
<input checked="" type="checkbox"/> Far: Exo Eso Strab Phoria	<input type="checkbox"/>
<input type="checkbox"/> Near: Exo Eso Strab Phoria	<input type="checkbox"/>
Refractive Status	
	RE LE
<input type="checkbox"/> Myopia _____	<input type="checkbox"/>
<input type="checkbox"/> Hyperopia _____	<input type="checkbox"/>
<input type="checkbox"/> Astigmatism _____	<input type="checkbox"/>
<input type="checkbox"/> Anisometropia _____	<input type="checkbox"/>
Ophthalmoscopy	
<input type="checkbox"/> OD _____	
<input type="checkbox"/> OS _____	
Tonometry (Time: _____)	
<input type="checkbox"/> OD _____	
<input type="checkbox"/> OS _____	
Other Tests & Notes:	
NPC (inches) Break _____ Recovery _____	
STÉREO _____ Test Name _____	
EYE MOVEMENTS _____	
OPTIONAL TESTING	
MEM _____ Target _____	
Acc. Facility _____	
Fusional Facility _____	
Plus Lens Test _____ Lens power _____	
Blood Pressure _____	
Color Vision _____	

SCREENING SUMMARY

PASS All test criteria have been met or exceeded and the individual will likely experience no visual difficulty for the present. Re-evaluation in one year is recommended.

FAIL A complete professional examination by the family eye care practitioner is indicated.

FAIL A complete professional examination by the family physician is indicated.

Note: If an examination is indicated, please present this form to the appropriate health care practitioner. This will assist him/her in the evaluation. We urge you to seek an eye care practitioner who understands, tests, and treats the possible visual skill deficiencies noted.

Comments: _____



COALICION DE MIGRANTES E INDIOS (OREGON - MHS)
Inscripcion - Enrollment Application

**MIGRANT & INDIAN COALITION
 FOR COORDINATED CHILDCARE INC.**

P. O. BOX 203 • WOODBURN, OR 97071
 (503) 981-0135 • FAX (503) 981-0176

Centro de Head Start para Migrantes: _____
 Local Migrant Head Start Center

Fecha de Inscripcion: _____ **¿Donde?** Casa Centro
 Date of Entry Intake Location Home Home Center

Nombre(s) **Apellido** **FDN** **NSS**
 First Middle Last DOB SSN

Padre: _____
 Father

Madre: _____
 Mother

Tutor: _____
 Legal Guardian

Direccion: _____
 Address

Telefono: _____ **Tel. Para Mensajes:** _____
 Phone Message Phone

(Check One Only)

Tipo de Familia: **Madre-Padre** **Madre** **Otro** **Padre** **Tutores**
 Family Type Mother-Father Mother Only Other Father Only Foster

(Check One Only)

Etnia: **Anglo** **Hispano** **Asiatico** **Nativo Americano** **Africano Americano** **Otro**
 Ethnicity Anglo Hispanic Asian Native American African American Other

Codigo de la Clase Class Code	Nombre(s) del Niño(s) Children in Family			Apodo Nickname	FDN DOB	Edad Age	Sexo Sex	NSS SSN
	Nombre(s) First Middle	Apellido Last						

Otros Familiares en la Casa:
 Other Family Members in Household:

Nombre/Fecha de Nacimiento
 Name/Birthdate

Nombre/Fecha de Nacimiento
 Name/Birthdate

Nombre/Fecha de Nacimiento
 Name/Birthdate

Total de Miembros en la Familia: _____ **(Incluye todas las personas que dependen del salario en la forma de elegibilidad)**
 Total number in family (Include all persons dependent on the income shown on the eligibility determination form).

	Padre Father			Madre Mother		
	Habla Speaks	Lee Reads	Escribe Writes	Habla Speaks	Lee Reads	Escribe Writes
Primer Idioma Primary Language						
Segundo Idioma Secondary Language						
Tercer Idioma Third Language						

¿Que idioma(s) hablan los niño(s)? _____
Language(s) spoken by children:

Nivel de Educacion:
Education level:

Padre _____ **Madre** _____ **Comentarios** _____
Father Mother Comments

Su niño, ¿ha recibido alguna vez servicios de lenguaje, audicion, vision o para alguna incapacidad? _____ **Si** _____ **No** _____
Has your child ever received services for speech, hearing, vision or other disability? Yes No

¿Cual niño? _____ **¿Que tipo de incapacidad?** _____
Which child? What type of disability?

Inscripciones previas en Head Start: _____ **Si** _____ **No** _____
Previous Head Start Enrollment Yes No

Si la respuesta es positiva, ¿cual niño(s)?
If yes, which child(ren)?

Niños Children	Cantidad de año(s) en Head Start (Sin incluir el presente año) # of year(s) in Head Start (NOT including current year)	¿Donde? Where?



MIGRANT & INDIAN COALITION
FOR COORDINATED CHILDCARE INC.

PROBLEM SHEET

Problem	Date	Treatment or Action	Plan	Date Resolved

APPENDIX D

Age Appropriate Screens for Children in Study

Screening	Age group			
	6-12mo.	>12-15mo.	>15-24mo	>24-36+mo.
Premature	1	1	1	1
Disability	1	1	1	1
Height	1	1	1	1
Weight	1	1	1	1
Head cir.	1	0	0	0
Hearing	1	1	1	1
Vision	0	0	0	1
Dental	0	0	1	1
DTP	1	1	1	1
OPV	1	1	1	1
MMR	0	0	1	1
Hib	1	1	1	1
Hep B	1	0	0	0
T.B	0	1	1	1
Hct.	0	1	1	1
total	10	10	12	13

Note. 1 = appropriate, 0 = not appropriate for age

APPENDIX E



OREGON
HEALTH SCIENCES UNIVERSITY

3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098
Mail Code L106, (503) 494-7887 Fax (503) 494-7787

Institutional Review Board/Committee on Human Research

DATE: March 21, 1994

TO: Roberta Packard SN-CHC
c/o Dr. Caroline White, Advisor

FROM: Nancy White, Administrative Asst. L-106
Committee on Human Research *N White*

SUBJECT: Project Title - Health Problems of Children Attending a Migrant
Head Start Program.

It is my understanding that the above-referenced project involves the study of existing data and that the information obtained will be recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. Therefore, the above-entitled study falls under category #4 of the federal regulations (45 CFR Part 46.101 (b)) and is considered to be exempt from review by the Committee on Human Research.

This study has been put into our exempt files, and you will receive no further communication from the Committee concerning this study. However, if the involvement of human subjects in this study changes, you must contact the Committee on Human Research to find out whether or not these changes should be reviewed. If possible, please notify the Committee when this project has been completed.

If you have any questions regarding the status of this study, please call me at 494-7887.




MIGRANT & INDIAN COALITION
FOR COORDINATED CHILDCARE, INC.

Hillsboro Center
265 S.E. Oak, Building A
Hillsboro, OR 97123
(503) 640-2666
(503) 648-6291 FAX

INTER-OFFICE MEMORANDUM

March 5, 1994

TO: Roberta Packard, RN

FROM: Linda Jaramillo 

RE: Research Project

I am pleased that you have chosen Migrant Head Start as the subject of your Master's Research Project. The project description that you outlined in your memo of February 14 will greatly benefit our program. As you know, we have long needed a comprehensive examination of the health needs of our children. I know we have a long way to go, but I believe we do a monumental job of providing the minimum of services to the children in the short time they are here and within current budget constraints. Your research will not only help us to see the specific needs of the children, but will provide us with more appropriate information on which to base our work plans.

Roberta, I have the highest respect for your commitment to confidentiality. I know the records you use will be kept in that domain. Thank you for emphasizing that concern. Please let me know if I can be of further assistance, please let me know. Best of luck in your project, and I look forward to the results.