

HEALTH - SUMMARY OF SERVICES

CHILD'S NAME _____

DATE	PROGRESS NOTE #	SERVICE
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H1. CERTIFICATE OF IMMUNIZATION STATUS

IMMUNIZATION REVIEW FORM

Waived Complete Up-to-Date/On Schedule Behind Schedule

H2. DEVELOPMENTAL HISTORY

Complete

H3. HEALTH HISTORY

Complete

PRENATAL HEALTH HISTORY

Complete

H4. MEDICAL ALERTS/ALLERGIES

Date <input type="checkbox"/>	Severe Allergy	Date <input type="checkbox"/>	Food Allergy	Date <input type="checkbox"/>	Asthma	Date <input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Protocol Completed	<input type="checkbox"/>	Special Diet/Food Sub. Form Completed	<input type="checkbox"/>	Asthma Management Protocol Completed	<input type="checkbox"/>	Protocol Completed

H5. VISION SCREENING

Complete

H6. AUDIO SCREENING

Complete

H7. NUTRITION ASSESSMENT

WIC Recipient Non-WIC Recipient Referred to Registered Dietitian

H8. HEALTH APPRAISAL/WELL CHILD EXAM

Prenatal/ Date	Newborn/ 2wk/Date	2 mo/Date	4 mo/Date	6 mo/Date	9 mo/Date	12 mo/Date	15-18 mo/Date	2 yr/Date	3 yr/Date	4 yr/Date	5 yr/Date

H9. DENTAL SCREENING (EHS)

DENTAL EXAMS (EHS/HS)

90 days/Date	6 mo/Date	6 mo/Date	6 mo/Date	6 mo/Date	6 mo/Date	2 yr/Date	3 yr/Date	4 yr/Date	5 yr/Date

FLUORIDE VARNISH APPLICATION

Concerns Noted

H10. LEAD SCREENING

Complete

H11. INTERNAL REFERRAL

H12. INCIDENT REPORT

Date _____ Date _____
 Injury: _____ Injury: _____

H13. EMERGENT HEALTH CONCERNS/ISSUES

H14. MEDICATION ADMINISTRATION AUTHORIZATION

H15. HEALTH COMPONENT APPOINTMENTS AND TRACKING