HEALTH CONTACT FORM
Alameda County Social Services

***This form is used to track health services for children in foster care*.**

Section A (To be completed by Caregiver)

Child's Name: **DOB:**

Caregiver's Name: Telephone #:

CWW: CWW's Telephone #:

Section B (To be completed by Health Care Provider)

Date of visit: _____ (Please date this form)

(✓) **Type of Visit:**

MEDICAL	DENTAL	OPTICAL	SPECIALTY
❑ CHDP/Routine Comprehensive	❑ Exam & Prophylaxis	❑ Initial Visit	❑ Type:_____
❑ Sick Visit/Urgent Care	❑ Follow-up	❑ Follow-up	
❑ Follow-up	❑ X-Rays		❑ Follow-up

TODAY'S FINDINGS: ***(Lab tests, screening, etc)***

Wt _____ Ht _____ Head Cir. _____

Hgb/Hct: _____ Lead Level: _____

Vision: _____ ❑Normal ❑ Referred

Hearing: _____ ❑ Normal ❑ Referred

DIAGNOSIS: ***(Must be provided)***

MEDICATION/TREATMENT:

COMMENTS:

REFERRED TO: ***(Specify provider if known)***

❑ Medical Specialty _____

❑ Developmental Assessment _____

❑ Speech/Hearing _____

❑ Early Start _____

❑ Regional Center _____

❑ Mental Health _____

❑ Other _____

IMMUNIZATIONS:

(Check (✓) if Given Today)

	Dose #				
	1	2	3	4	5
Hep B					
Rota					
DTaP					
Hib					
PCV					
IPV					
MMR					
Varicella					
Hep A					
MCV4					
HPV					
Td/Tdap					

❑ **PPD** Results: _____

❑ **Flu Shot**

❑ **Other:** _____ _____ _____

PROVIDER'S INFO: ***(*****Please stamp or print)**

Name:_____

Address:_____

Telephone #: _____

Fax #: _____

Provider's Signature: _____

Date: _____

***Please return completed form to*:**

Health & Education Passport Unit; 24100 Amador Blvd. (#601B); Hayward, CA 94544