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# City and County of San Francisco
# Human Services Agency

FCS Nursing Unit
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**1132-C HEALTH AND DENTAL FORM**

Please complete this health form for every medical, dental and specialty visit.

## SECTION A: TO BE COMPLETED BY THE RESOURCE PARENT

**Child's Name:** _____ (LAST) _____ (FIRST) **DOB:** _____

**Social Worker/Probation Officer:** _____ **Phone Number:** _____

**Resource Parent:** _____ **Phone Number:** _____

## SECTION B: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

**TYPE OF VISIT:** **Date of Exam:** _____

| MEDICAL | DENTAL | SPECIALTY |
|---|---|---|
| ☐ Well Child Exam | ☐ Exam and Prophylaxis | _____ Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health) |
| ☐ Immunization Visit | ☐ Treatment | ☐ Initial Consultation |
| ☐ Sick Visit/Urgent Care | ☐ Orthodontics | ☐ Follow Up |
| ☐ Reproductive Health | ☐ Follow-Up | |
| ☐ Follow-up | | |

**TODAY'S FINDINGS:** (Lab Tests, Screens)

_____ Height (_____ %) _____ Weight (_____ %) _____ BMI (_____ %) _____ Head Circumference (_____ %)

☐ Hemoglobin
☐ Hematocrit _____ Lead _____ Vision R: _____ L: _____ Hearing R: _____ L: _____

Other: _____

Any known **allergies** to medication/food/environment? ☐ **N** ☐ **Y** Please list: _____

**ASSESSMENT/DIAGNOSIS:**

**MEDICATIONS/TREATMENTS:** (DOSAGE/FREQUENCY)

If prescribed psychotropic medication, was a JV220(A) completed? ☐ Y ☐ N

**DEVELOPMENTAL SCREENING/ASSESSMENT:** **Completed today?** ☐ Y ☐ N

**Developmental tool used, if any:** (Please attach a copy) ☐ **ASQ-3** ☐ **ASQ-SE** ☐ **Other** (Specify): _____

**Age appropriate development** ☐ Y ☐ N **If NO, Indicate:**

☐ Gross ☐ Fine ☐ Speech/Language ☐ Social/Emotional ☐ Cognitive

**Physical Growth** ☐ WNL ☐ Delayed _____

**REFERRALS:** **(i.e.: Mental Health, Dental, CCS, Speech and Hearing, IEP)**

**FOLLOW UP APPOINTMENT(S) NEEDED?** ☐ **N** ☐ **Y** **Date/Time:** _____

### IMMUNIZATIONS

☐ **Copy of IZ Records Attached?**

**Check (☑) which immunizations have been given TODAY:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **IPV** | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | | |
| **DTaP** | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | |
| **Td** | ☐ | | | | | |
| **Tdap/Booster** | ☐ | | | | | |
| **Hib** | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | | |
| **MMR** | 1 ☐ | 2 ☐ | | | | |
| **Hep B** | 1 ☐ | 2 ☐ | 3 ☐ | | | |
| **Hep A** | 1 ☐ | 2 ☐ | | | | |
| **VZV** | 1 ☐ | 2 ☐ | | | | |
| **PCV** | 1 ☐ | 2 ☐ | 3 ☐ | 4 ☐ | 5 ☐ | |
| **PCV13** | ☐ | | | | | |
| **MCV4** | ☐ | | | | | |
| **HPV** | 1 ☐ | 2 ☐ | 3 ☐ | | | |
| **Influenza** | 1 ☐ | 2 ☐ | | | | |
| **Rotavirus** | 1 ☐ | 2 ☐ | 3 ☐ | | | |

Other: _____

☐ **PPD** ☐ **QuantiFERON**
☐ **Given** (Date) _____
☐ **Read** (Date) _____
Result: ☐ Negative ☐ Positive

**HEALTH CARE PROVIDER INFORMATION:** (Please print or stamp)

**SERVICE LOCATION:** (Group Name, Provider's Address, Phone & Fax Number)

_____
_____
_____
_____

**NPI or Group Number** (if available)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

_____ **Health Care Provider's Printed Name**

_____ **Date of Exam**

_____ **Health Care Provider's Signature**

 **Email completed form to: NOD.line@sfgov.org or mail to: FCS Nursing Unit P.O. Box 7988 San Francisco, CA 94120-7988**