Clear Form

San Joaquin County Human Services Agency

Foster Care Nursing
San Joaquin County, Human Services
PO Box 201056, Stockton, CA
95297-0106
Phone:(209)468-1408
fax: (209)932-2638

Please complete this form for every medical, dental and specialty visit (including CHDP examination).

SECTION A: TO BE COMPLETED BY THE CAREGIVERS

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

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

Caregiver: _____ **Phone Number:** _____

SECTION B: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

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

MEDICAL	DENTAL	SPECIALTY
☐ CHDP/Well Child Exam	☐ Exam and Prophylaxis	☐ _____ Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health)
☐ Immunization Visit	☐ Treatment	☐ Initial Consultation ☐ JV220 (A or B)attached
☐ Sick Visit/Urgent Care	☐ Orthodontics	☐ Follow-Up
☐ Reproductive Health	☐ Follow-Up	
☐ Follow-up		

TODAY'S FINDINGS: (Lab Tests, Screens)

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

Hgb/Hct _____ 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)

DEVELOPMENTAL SCREENING/ASSESSMENT: Age appropriate development ☐ Y ☐ N

Screening or Assessment Completed today? ☐ N ☐ Y (Please attach a copy)

Type: ☐ ASQ-3 ☐ ASQ-SE ☐ Other (Specify): _____

Physical Growth ☐ WNL ☐ Delayed _____

☐ Developmentally delayed: ☐ Motor: ☐ Gross ☐ Fine ☐ Speech/Language ☐ Social/Emotional ☐ Cognitive

REFERRALS: (Examples: Mental Health, Dental, CCS, Speech and Hearing, IEP)

FOLLOW UP APPOINTMENTS 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/TB Test

☐ Given ☐ Read (Date)_____ ☐ Neg. ☐ Pos.

HEALTH PROVIDER INFORMATION: (Please print or Stamp)

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

_____

_____

_____

_____

NPI or Group Number (if available)

_____ Health Provider's Printed Name

_____ Date of Exam

_____ Health Provider's Signature

Foster care providers: mail completed form to: Foster Care Nursing, SJCHuman Services Agency, PO Box 201056, Stockton CA. 95297-0106 or fax to Foster Care Nursing (209)932-2638

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Email