

UMATILLA-MORROW HEAD START-HEALTH COMPONENT
APPOINTMENTS AND TRACKING

Child's Name on Medical Card _____ Date _____

DOB _____ Classroom _____

Nutrition Assessment Appointment Date _____

Well Child Appointment Date _____

Medical (Home) Clinic _____

Dental Appointment Date _____

Dental (Home) Clinic _____

Child has visible decay _____ Yes _____ No

Health Insurance _____ Yes _____ No

Date Applying for Insurance _____

Possible Voucher Needed _____ Yes _____ No

Hearing and Vision Concerns _____ Yes _____ No

Immunizations Up to Date _____ Yes _____ No

Needs UMCHS Lead Test _____ Yes _____ No

Protocol or Food Substitution Form Required _____ Yes _____ No

Completed _____ Yes _____ No

Asthma Seizure Allergy Food Substitution Other _____

Notes: _____

Family Advocate/CFA Signature _____

Health Staff Signature _____

