HEALTH SCREENING PROGRESS SHEET

Child: _____ **Area/CB #** _____ **Program Year:** _____ **Staff:** _____

Early Head Start: Check box when complete or N/A.	**Head Start:** Check when <u>complete for year</u>; put due date on line if due within the year.
WBCs ☐ 1mo ☐ 2mo ☐ 4mo ☐ 6mo ☐ 9mo ☐ 12mo ☐ 15mo ☐ 18mo ☐ 24mo ☐ 30mo ☐ 36mo **Hemoglobin** (due at) ☐ 12mo **Lead** (due at) ☐ 12mo & ☐ 24mo **TB** (due at) 12mo ☐ **Dental** (due at) ☐ 36mo **Vision & Hearing** (due at) ☐ 36mo **Immunizations (complete for year)** ☐	☐ **Physical** exp. _____ ☐ **Hemoglobin** ☐ **Lead** ☐ **TB** ☐ **Dental** exp. _____ ☐ **Immunizations** ☐ **Vision & Hearing** _____

Health Need **(list each need on own line)**	**Contact**		**S u p p o r t** **Code**	**ACTIVITY** **Status/Updates/Support/Title of Ed. Handout** **Contact type codes: H**-home visit, **N**-written note, **P**-phone call, **S**-scheduled conference at site, **B**-brief verbal reminder at site. **Support offered codes: T**-transportation, **F**-financial, **E**-Ed. handout	**Date to C.O.**
	d a t e	**t y p e**			
Document 2nd contact and beyond on this form				**If child needs medical, or dental treatment/follow up, staff will receive a follow up progress sheet from C.O. and document support and activities on it and not this form.**	

H5/16

Child: _____ **Area/CB #** _____ **Program Year:** _____ **Staff:** _____

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H5/16