HEAD START
PARENT HELD CHILD HEALTH RECORD
(Continuity Record)

Child's Name _____

Child's SS # _____

Birthdate _____

Enrollment Date _____ Withdrawal Date _____

Center Name _____

Address _____

Telephone No. ( ) _____

Enrollment Date _____ Withdrawal Date _____

Center Name _____

Address _____

Telephone No. ( ) _____

Enrollment Date _____ Withdrawal Date _____

Center Name _____

Address _____

Telephone No. ( ) _____

Enrollment Date _____ Withdrawal Date _____

Center Name _____

Address _____

Telephone No. ( ) _____

MIGRANT HEAD START
PARENT HELD CHILD HEALTH RECORD
(Continuity Record)

Child's Name _____

Birthdate _____

Father _____

Mother _____

No. of Siblings ages 0-6 yrs. _____

Permanent Address of Family _____

_____

MSRTS # _____

ALLERGIES
Drugs _____
Others _____

IMMUNIZATION

DPT	1	2	3	Booster	Booster
	2 mos.	4 mos.	6 mos.	18 mos.	4-6 yrs.
Date					

POLIO	1	2	3	Booster
	2 mos.	4 mos.	18 mos.	4-6 yrs.
Date				

	MSLES. 15 mos.	RUB. 15 mos.	MUMPS 15 mos.
Date			

Date	TB TESTS TYPE	TYPE RESULTS	FOLLOW-UP (X-Rays, Etc.)

MEDICAL EXAM

DATE OF EXAM	CLINIC	ADDRESS/PHONE

MEDICAL SCREENINGS

	STOOL	LEAD	SICKLE CELL	HGB/ HCT	BP
DATE					
RESULT					
DATE					
RESULT					
DATE					
RESULT					
DATE					
RESULT					

	SPEECH LANG	VISION	HEARING	DEVELOP. SCREENING
DATE				
TYPE				
PASS/ FAIL				
DATE				
TYPE				
PASS/ FAIL				
DATE				
TYPE				
PASS/ FAIL				

PROBLEM LIST

(A) Active (I) Inactive (F) Follow-up Needed

Date	Problem	A—I—F

DATE	Current medical treatment and prescribed medication	Follow-up Needed (✓)

WIC

Date of Certification _____ Date of Expiration _____

County _____ State _____

DIAGNOSTIC CODE

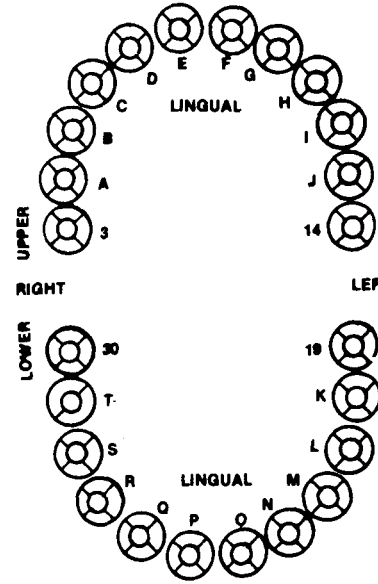
Horizontal stripes indicate Stainless Steel Crown covering tooth entirely.

Solid area indicates filling present.

Zebra Stripes indicate decay present.

Vertical Line indicates to be extracted.

"X" Indicates a missing tooth.



DENTAL PROCEDURES

*Record date in square

DENTAL EXAM	X-RAY	PROPHY	FLOURIDE Water (FW), Tablets (FT) Rinse (FR)	DENTIST/CLINIC Name/Address

DATES IN AREA OF FLOURIDATED WATER	FROM TO	FROM TO	FROM TO	FROM TO
DATES USED FLOURIDE TABLETS/DROPS (GIVEN DAILY)	FROM TO	FROM TO	FROM TO	FROM TO
DATES USED MOUTH RINSE (DONE WEEKLY)	FROM TO	FROM TO	FROM TO	FROM TO

DENTAL TREATMENT

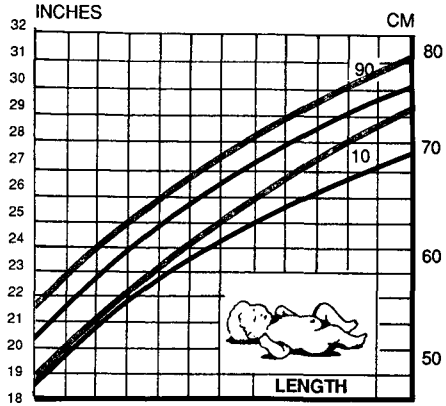
DENTAL WORK (C) COMPLETED (I) INCOMPLETE (F) FOLLOW UP NEEDED

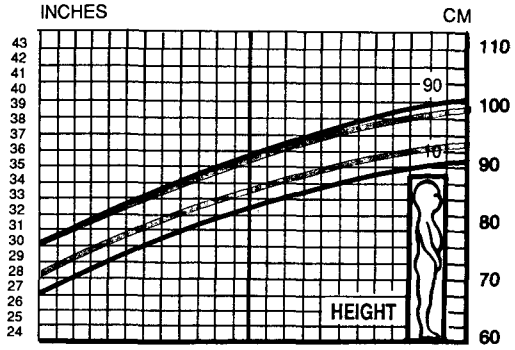
DATE	PROBLEM	(C) (I) (F)

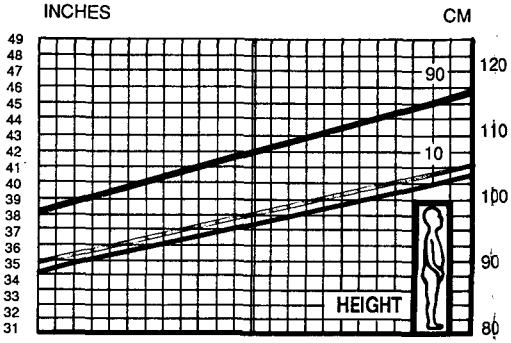
GROWTH ASSESSMENT

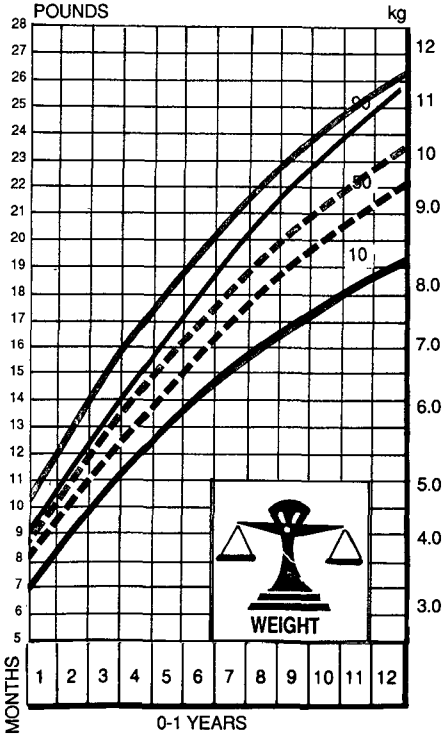
BLACK GRID LINE FOR GIRLS

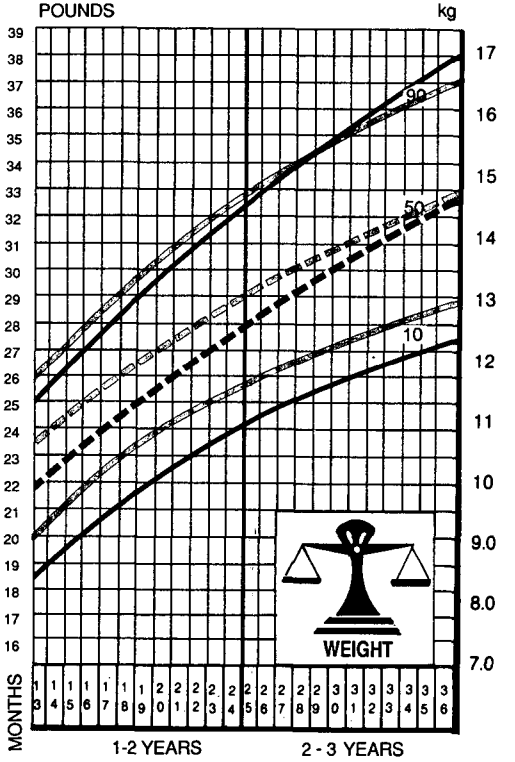
RED GRID LINE FOR BOYS

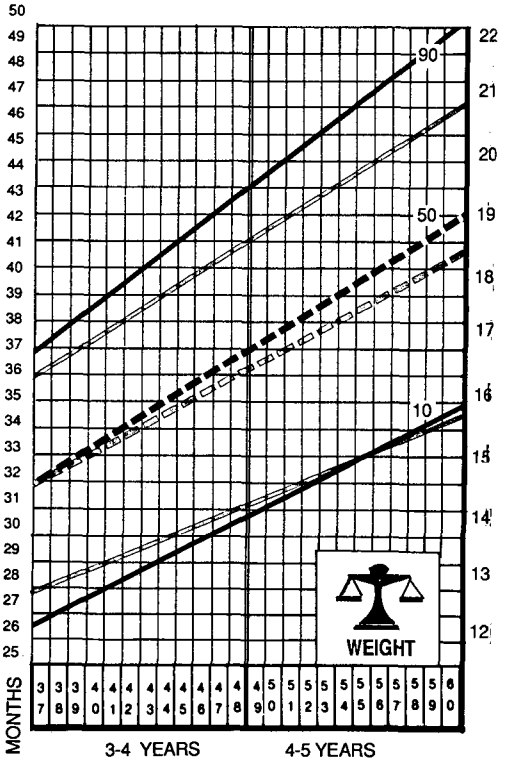












Date													
WEIGHT													
✓ if greater than 90% or less than 10%													
HEIGHT													
✓ if greater than 90% or less than 10%													
Infant head circumference													

IMPORTANT

Instructions to Parents

(1) Keep this record with you at all times.
(2) Show it when child is enrolled in an Early Childhood Program or makes visits for any type of health care. It will help you receive proper care for your child.

Instructions to Early Childhood Programs

(1) This continuity record belongs to the parents
(2) Use it to gather the information you need and return it to the parents.

IMPORTANTE

Instrucciones para los Padres

(1) Siempre retenga esta tarjeta con usted.
(2) Presente esta tarjeta cuando inscriba a su niño en un programa de niñez o cuando vaya a recibir servicios de salubridad. Le ayudará a recibir servicios propios para su niño.

Instrucciones para Programas de Niñez

(1) Este documento de continuidad le pertenece a los padres.
(2) Use este documento para su información y devuélvalo a los padres.

COMMENTS: