City and County of San Francisco
Human Services Agency

FCS Nursing Unit
P.O. Box 7988
San Francisco, CA 94120-7988
Ph: (415) 558-2656 • Fax: (415) 355-2357
email: NOD.Line@sfgov.org

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:

Vaccine					
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