HEALTH CONTACT FORM
Alameda County Social Services

This form is used to track health services for children in foster care.

Section A (To be completed by Caregiver)

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>DOB:</th>
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<tbody>
<tr>
<td>Caregiver’s Name:</td>
<td>Telephone #:</td>
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<tr>
<td>CWW:</td>
<td>CWW’s Telephone #:</td>
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Section B (To be completed by Health Care Provider)

Date of visit: ___________________ (Please date this form)

(✓) Type of Visit:
- MEDICAL
  - CHDP/Routine Comprehensive
  - Sick Visit/Urgent Care
  - Follow-up
- DENTAL
  - Exam & Prophylaxis
  - Follow-up
- OPTICAL
  - Initial Visit
  - Follow-up
- SPECIALTY
  - Type: ____________

TODAY’S FINDINGS: (Lab tests, screening, etc)

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Hgb/Hct: ___________  Lead Level: ___________

Vision: _____________  Normal  Referred

Hearing: _____________  Normal  Referred

DIAGNOSIS: (Must be provided)

MEDICATION/TREATMENT:

COMMENTS:

REFERRED TO: (Specify provider if known)

- Medical Specialty _____________________________
- Developmental Assessment ______________________
- Speech/Hearing ________________________________
- Early Start ____________________________________
- Regional Center ______________________________
- Mental Health _________________________________
- Other ________________________________________

IMMUNIZATIONS: (Check ✓ if Given Today)

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<tr>
<th>Dose</th>
<th>Hep B</th>
<th>Rota</th>
<th>DTaP</th>
<th>Hib</th>
<th>PCV</th>
<th>IPV</th>
<th>MMR</th>
<th>Varicella</th>
<th>Hep A</th>
<th>MCV4</th>
<th>HPV</th>
<th>Td/Tdap</th>
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- PPD Results: ______
- Flu Shot
- Other: _____________

PROVIDER’S INFO: (Please stamp or print)

Name: _____________________________

Address: __________________________

Telephone #: _______________________

Fax #: ____________________________

Provider’s Signature: __________________

Date: ____________________________

Please return completed form to:
Health & Education Passport Unit; 24100 Amador Blvd. (#601B); Hayward, CA 94544