SAN BERNARDINO COUNTY CHILDREN and FAMILY SERVICES
REPORT OF MEDICAL / DENTAL EXAM

FOR HEALTH PASSPORT UPDATE
FAX or RETURN in the POSTPAID ENVELOPE FFA must give original to social worker or PHN

PUBLIC HEALTH NURSE

CHILD: _____

CWS # _____

DOB: _____

WORKER NAME: _____

TO BE COMPLETED BY THE MEDICAL / DENTAL PROVIDER: ICD-9 (IF EASILY AVAILABLE)

DX: _____

RX: _____

Immunizations Given Today: (Please Check)

- ☐ DtaP #1
- ☐ DtaP #2
- ☐ DtaP #3
- ☐ DtaP #4
- ☐ DtaP #5
- ☐ Td/Tdap #6
- ☐ Hep B #1
- ☐ Hep B #2
- ☐ Hep B #3
- ☐ IPV #1
- ☐ IPV #2
- ☐ IPV #3
- ☐ IPV #4
- ☐ MMR #1
- ☐ MMR #2
- ☐ PCV #1
- ☐ PCV #2
- ☐ PCV #3
- ☐ PCV #4
- ☐ Hib #1
- ☐ Hib #2
- ☐ Hib #3
- ☐ Hib #4
- ☐ Varcella #1
- ☐ Varcella #2
- ☐ HEP A #1
- ☐ HEP A #2
- ☐ Rota #1
- ☐ Rota #2
- ☐ Rota #3
- ☐ MCV
- ☐ HPV #1
- ☐ HPV #2
- ☐ HPV #3
- ☐ Influenza

Other Immunizations: _____

Results of tests done today

HEIGHT _____ HEARING _____
Head circ<2yr_____
WEIGHT _____ VISION _____
☐ BMI _____
☐ BP _____/____
☐ TB TEST _____ RESULTS _____

☐ HGB _____
☐ LEAD SCREENING: _____

OTHER TEST: _____

TYPE OF VISIT: ☐ Medical ☐ Dental ☐ Vision
Purpose:
☐ Routine Comprehensive (Well Child)
☐ Specialist visit ☐ Tx Completed
☐ Sick visit ☐ Tx Ongoing

☐ Follow up _____

☐ Medication prescribed _____

WAS CHILD REFERRED TO ANOTHER PROVIDER? ☐ NO ☐ YES (If Yes, please complete)

Name: _____ Specialty: _____

Address: _____ To be seen by what date: _____

_____ Telephone: ( ) _____

Date of Service: _____

PROVIDER STAMP
HERE

Print Provider Name - Please Add Stamp:

_____

Address: _____

City/State: _____

Phone: (_____) _____

TDD – Telephone Services For The Hearing Impaired (909) 386-9780
Child and Adult Abuse Hotline 1 (800) 827-8724

Distribution: Original - Case Record
Copy - Caretaker