Health and Nutrition School Readiness Transition Information

Check One: ❑ Family Visit or ❑ Conference ***Complete when**: child transitions out of the program or between classrooms*

Child: _____ Teacher/Provider: _____ Date: _____

Immunization Status:	**Physical Exam:**
❑ Complete for Kindergarten ❑ Needs following immunizations (check) ❑ DTP ❑ Polio ❑ MMR ❑ Hep B ❑ Varicella ❑ HIB ❑ PCV	Date of last exam: _____ Next exam due: _____ Follow up needed for: _____ Date of last HCT/HGB: _____ Value: _____ Date of last Lead: _____ Value: _____
Information to provide to families: ❑ Certificate of Immunization Status (original→parent, copy→file) ❑ Growth Grids ❑ Child Health Plan (CHP) *(if applicable)* (original→file, copy→parent) ❑ Return medications *(if applicable)*	**Dental Exam:** Date of last exam: _____ Next exam due: _____ Follow up needed for: _____ _____

Was the child referred for any health or nutrition concern (hearing, vision, speech, dietary, or growth) that requires follow up? ❑ No ❑ Yes If yes, indicate below:

_____

_____ _____

Parent signature Date Interpreter signature (if needed) Date

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Revised 04/2016
07.007.08 SJudie
Page 1 of 1