SEQUATCHIE VALLEY HEAD START
HEALTH/MENTAL HEALTH TRACKING FORM

Child's name: _____ Center: _____
Parent/Guardian name: _____ Date tracking begun:_____
The need/problem is:

____low hct or hgb/anemia
____needs dental exam
____at risk for overweight
____at risk for underweight
____failed developmental screening
____failed vision screen/referred to eye doctor
____failed hearing screen/referred to doctor
____failed hearing screen/referred to speech & hearing ctr
____failed dental exam/referred for treatment
____social/emotional/behavioral needs identified
____physical exam revealed an abnormality:(specify)_____
____immunizations needed. List shots currently needed:_____
____other health/mental health problem:please specify._____
Expected outcome:_____
_____

Document below contacts made by Head Start staff regarding the above need/problem.

1)Date of contact_____Employee's name_____
Summarize contact:_____
_____
_____

2)Date of contact_____Employee's name_____
Summarize contact:_____
_____
_____

3)Date of contact_____ Employee's name_____
Summarize contact:_____
_____
_____

4)Date of contact_____ Employee's name _____
Summarize contact:_____
_____
_____

5)Date of contact_____ Employee's name _____
Summarize contact:_____
_____
_____

Date need met/problem solved: _____