Health Passport

**HEALTH VISIT REPORT**

| 1.NAME OF PROVIDER (Print or Type) | 4. CHILD'S NAME | 5. DATE OF VISIT |
|---|---|---|
| 2. FACILITY (Name and Address) | 6. CHILD'S BIRTH DATE | |
| | 7. WORKER NAME AND ID # | |
| 3. TELEPHONE | 8.WORKER TELEPHONE | |

**A. TYPE OF VISIT**

| | |
|---|---|
| 1. ☐ INITIAL HEALTH SCREEN | 5. ☐ DENTAL VISIT |
| 2. ☐ COMPREHENSIVE HEALTH ASSESSMENT | 6. ☐ VISION SCREENING |
| 3. ☐WELL CHILD/EPSDT/HEALTHY KIDS | 7. ☐ OTHER (specify) |
| 4. ☐ SICK/ EMERGENCY | |

**B. VISIT INFORMATION** (is completed by Health Care Provider or (2) copies of Providers Report must be attached)

**1.** ASSESSMENT / DIAGNOSIS:

**2.** IMMUNIZATIONS**:**

**3**. FOLLOW UP NEEDED? (explain, and indicate if condition requires ongoing visits, noting frequency and expected completion dates).

| **PROVIDER SIGNATURE** | **DATE** |
|---|---|
| | |