

**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 | ___ failed vision screen/referred to eye doctor |
| ___ needs dental exam | ___ failed hearing screen/referred to doctor |
| ___ at risk for overweight | ___ failed hearing screen/referred to speech&hearing ctr |
| ___ at risk for underweight | ___ failed dental exam/referred for treatment |
| ___ failed developmental screening | ___ 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: _____