LCCS 7009
Rev 5/2024

Lucas County Children Services

Health Visit Report

Child's Name _____ **Date of Birth** _____

Type of Visit - This section must be completed **Date of Visit** _____

- ☐ Comprehensive Physical *(which includes healthcheck requirements and vision and hearing screenings appropriate for age e.g., tracking, tuning fork, Snellen)*
- ☐ Dental Appointment
- ☐ Follow-Up ☐Treatment Ongoing ☐Treatment Completed
- ☐ Sick Visit
- ☐ Specialist Visit *(vision, hearing evaluation)*
- ☐ Emergency Room Treatment

Height:		Weight:
Temp:	BP:	P:
Head Circumference:		
Hgb:		
Lead:		
Sickle Cell:		

Diagnosis _____

Treatment *(Describe medical/dental treatment and prescriptions ordered)* _____

Immunization(s) Given TODAY *(please check)*

☐ DPT/DT/Td # 1	☐ HBV # 1	☐ HIB # 1	☐ IPV #1	☐ MMR #1	☐ PCV # 1
☐ DPT/DT/Td # 2	☐ HBV # 2	☐ HIB # 2	☐ IPV #2	☐ MMR #2	☐ PCV # 2
☐ DPT/DT/Td # 3	☐ HBV # 3	☐ HIB # 3	☐ IPV #3		☐ PCV # 3
☐ DPT/DT/Td # 4		☐ HIB # 4	☐ IPV #4	☐ Prevnar	☐ PCV # 4
☐ DPT/DT/Td # 5					
		☐ HPV		☐ TB Test	☐ Varicella

Other: _____

Tests *(Completed today and results, if available (e.g., dental x-ray and/or results, urinalysis, throat culture)*

_____

Other Areas of Concern ☐ Social ☐ Educational ☐ Developmental ☐ Emotional
☐ Other: _____

Child was Referred to: Name _____ Specialty _____

Please ask the ☐ LCCS Caseworker ☐ LCCS Health Services RN to contact the physician's office below regarding: _____

_____

Medical Provider's Signature *(Doctor/Dentist/Specialist)* Date

_____

Print or Stamp Name & Address of Physician ***(This must be completed)***

LCCS Health Services: 419-213-3205/419-213-3481 Fax: 419-327-3358
Email: Lucaskids-Clinic@jfs.ohio.gov