<table>
<thead>
<tr>
<th>Client Name:</th>
</tr>
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</table>

**Last** | **First** | **MI** | **Relationship to Infant (check one):** □ Mother  □ Father  □ Grandparent  □ Foster Parent  □ Other Family  □ Other, please specify: |

| Relationship to Infant (check one): □ Mother  □ Father  □ Grandparent  □ Foster Parent  □ Other Family  □ Other, please specify: |

<table>
<thead>
<tr>
<th>Caretaker Name:</th>
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</table>

**Client**

- **Last** | **First** | **MI** |

**Caretaker Name:**

- **Last** | **First** | **MI** | **Relationship to Infant (check one):** □ Mother  □ Father  □ Grandparent  □ Foster Parent  □ Other Family  □ Other, please specify: |

**FEEDING/BREASTFEEDING**

- **Has the infant ever breastfed (including breastmilk supplemented with formula; check one)?** □ Yes □ No □ Unknown
- **Was the infant ever exclusively breastfed (check one)?** □ Yes □ No □ Unknown
  - **If yes, how long was the infant exclusively breastfed?** ____ months
  - **If no or unknown, was infant exclusively fed formula?** □ Yes □ No
- **If eating solid food, at what age did infant start (includes cereal mixed in bottle; check one)?**
  - 0-3 months  □ 4-6 months  □ 7-12 months  □ Unknown
- **Does infant have difficulty feeding: from bottle?** □ Yes □ No
- **Does infant have difficulty feeding: from breast?** □ Yes □ No
- **If mother was advised not to breastfeed, reason (check one):** □ Medical reasons □ Substance use □ Unknown
- **If breastfeeding stopped, what were the reasons (check all that apply):**
  - □ Infant had difficulty latching or nursing
  - □ Breast milk alone did not satisfy the baby
  - □ Infant was not gaining enough weight
  - □ Mother’s nipples got sore, cracked or bleeding
  - □ It was too hard, painful or time consuming
  - □ Infant was jaundiced
  - □ Substance use
  - □ Other: _________________________________________________________ □ Unknown

**HEALTH REVIEW**

- **Infant’s weight at closure:** ______ pounds ______ ounces  
  - **Infant’s length at closure:** ______ inches
- **Does infant have a medical home?** □ Yes □ No
- **Primary location for child’s regular medical checkups and sick care (check one):**
  - □ Doctor’s/nurse practitioner’s office
  - □ Hospital emergency room
  - □ Hospital outpatient
  - □ Federally qualified health center
  - □ Retail store or minute clinic
  - □ Unknown/did not report □ None
- □ Other (please specify): ______________________
- **Has infant kept all 8 well child visits with primary care provider, up to current age?** □ Yes □ No
- **Did client attend the following recommended dates of well-child visits (check all that apply):**
  - □ 5 days  □ 1 month  □ 2 months  □ 4 months  □ 6 months  □ 9 months  □ 12 months
  - **Immunizations up to date?** □ Yes □ No
  - **Date last received immunizations:**
- **If not up to date, please specify why not:** ________________________________________________________________
- **Does anyone in the client’s household (parent, sibling, etc.) use substances (excluding caffeine, mercury, pesticides)?** □ Yes □ No
  - **If yes, what substances:** ________________________________________________________________

**ORAL HEALTH**

- **Infant has access to dental care?** □ Yes □ No
- **Infant had his/her first dental appointment?** □ Yes □ No
- **Has the infant’s medical care provider had a conversation with the caretaker about age one (1) dental visit?** □ Yes □ No
- **Does infant have any teeth at case closure?** □ Yes □ No
- **Does infant have fluoride exposure via drinking water, supplements, professional applications or toothpaste?** □ Yes □ No
- **Does infant drink/eat sugary foods i.e. juice, carbonated or non-carbonated soft drinks, energy drinks?** □ Yes □ No
- **Did caretaker receive infant oral health education by RFTS provider?** □ Yes □ No
- **Is brushing teeth, flossing, and/or cleaning gums a part of the child’s daily routine? (check one):** □ Always □ Sometimes □ Never
- **Does infant fall asleep with a bottle? (check one):** □ Always □ Sometimes □ Never
- **Does guardian have concerns about the child’s teeth or gums?** □ Yes □ No
  - **If yes, please specify concerns:** ________________________________________________________________
# Detailed Health Review

## Medical Conditions (check all that apply):

- [ ] Acquired Immunodeficiency Syndrome (AIDS)
- [ ] Asthma and respiratory allergies
- [ ] Cancer
- [ ] Cerebral palsy
- [ ] Congenital heart disease
- [ ] Cystic fibrosis
- [ ] Diabetes
- [ ] Digestion disorders
- [ ] Down syndrome
- [ ] Emotional/mental health disorders
- [ ] Feeding difficulties in early childhood
- [ ] Genetic disorders
- [ ] Hearing impairment
- [ ] Heart disease/defects
- [ ] Human immunodeficiency virus (HIV)
- [ ] Juvenile arthritis
- [ ] Jaundice
- [ ] Overweight and obesity
- [ ] Prematurity and low birth weight
- [ ] Sickle cell anemia/disease
- [ ] Spina bifida/Neural tube defects
- [ ] Visual impairment
- [ ] Other (please specify): ______________________

## Developmental Conditions (check all that apply):

- [ ] Acquired brain injury and selected neurological disorders
- [ ] Motor delay and movement disorders
- [ ] Sensory processing disorder
- [ ] Other (please specify): ______________________

## Allergies (check all that apply):

- [ ] Environmental
- [ ] Food
- [ ] Medicines
- [ ] Other (please specify): ______________________

## Medicines and Supplements Taken Regularly (check all that apply):

- [ ] Over-the-counter drugs
- [ ] Ear drops
- [ ] Vitamin supplements
- [ ] Antibiotics
- [ ] Eye ointment
- [ ] Asthma inhalers
- [ ] Other (please specify): ______________________

According to the health care provider, is child’s size and weight OK?  
- [ ] Yes
- [ ] No

If no, please specify concerns about child’s size or weight: ______________________

Child has been screened for anemia?  
- [ ] Yes
- [ ] No
- [ ] Unknown

If yes, please specify results of anemia screening: ______________________

Child has been screened for lead levels?  
- [ ] Yes
- [ ] No
- [ ] Unknown

If yes, please specify results of lead screening: ______________________

## Safety Review

- There is at least one working smoke detector on each floor where the family resides.  
  - [ ] Yes
  - [ ] No

- Family has a plan and supplies in case of an emergency in the home or natural disaster.  
  - [ ] Yes
  - [ ] No

- Do you have any concerns about your physical living space that impact well-being or safety?  
  - [ ] Yes
  - [ ] No

  If yes, please specify: ______________________

## DCC Notes

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

DCC Signature: ___________________________ Service Date: __________

Region: _______ Agency: ___________________________ County: __________

Sign, then copy both sides of each sheet; original to DCC Agency and copy to RCC.