

CARING CONNECTIONS
12 Month Visit Form

(rev. 1/07)

OTTER TAIL COUNTY FAMILY
SERVICES COLLABORATIVE
UNIVERSAL HOME VISITING PROGRAM

Client ID # _____ FOR USE BY PUBLIC HEALTH ONLY
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Child's Name: _____ DOB: _____ Date of Visit: _____

Home Visitor: _____ Agency: _____

If this visit was not made during the 12th month, please indicate reason for delay:

CHANGE IN FAMILY INFORMATION (if any):

Change of Address: _____

Change of Phone #/Contact Information: _____

Change in living arrangement for parents: Married Separated Divorced Deceased
(circle one)

MEDICAL/HEALTH RELATED INFORMATION:

Did the child complete a full series of shots for 2, 4 and 6 months? Yes / No

Has child received/scheduled 12-month well-child exam by his/her doctor? Yes / No

Has the parent scheduled a 15-month well-child exam? Yes / No

Is child currently covered by health insurance? Yes / No

Does parent have any concerns about child's overall development? Yes / No

General Health Concerns or Questions Noted by Doctor/Parent since time of last visit:

Was child breast-fed at any time during infancy? Yes / No If yes, how would you best describe child's breast feeding:

____ Exclusive (no more than 1 or 2 mouthfuls of anything but breast milk in 24 hour)

For how long: _____

____ Nearly Exclusive (1 feeding or less per day of anything other than breast milk)

For how long: _____

____ Other (more than 1 feeding per day of anything other than breast milk)

For how long: _____

Why did mom discontinue breast feeding? _____

PARENT/CHILDCARE INFORMATION:

Is Mother currently employed outside the home? Y/ N Father currently employed

outside the home? Y/ N Note: _____

Is child currently enrolled in daycare? Y/ N If so, approximately how many hours per week? _____ Note: _____

Discuss Child Care Arrangements/Child Care Qualification/Suggestions (referral to Child Care Resource and Referral, if necessary.

Notes:

Date: _____

Signature of Home Visitor

