Child's Name:	
DOB:	
PID:	
Caregiver:	
Appointment Date:	
☐ After-care summary is attached to this form.	

Reason for Visit
☐ **3-Day Medical Exam** (Required within three business days of removal determined by DFPS)
☐ **Initial Texas Health Steps Medical Checkup** (Required within 30 days of entering DFPS conservatorship)
☐ **Routine Texas Health Steps Medical Checkup** (Required at the following ages: within five days after discharge from the newborn hospitalization, at 2 weeks of age, at 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 36 months, and then annually)
☐ **Vision Check** ☐ **Hearing Check**
☐ **Psychotropic Medication Review**
☐ **Other Medical Checkup** – Reason (injury, accident or illness):
☐ **ER Visit** – Reason:
☐ **Initial Texas Health Steps Dental Checkup** (Required within 60 days of entering DFPS conservatorship if the child is 6 months of age or older, or within 30 days of turning age 6 months)
☐ **Routine Texas Health Steps Dental Checkup** (Required every six months or as recommended by a dentist)
☐ **Other Dental Checkup** – Reason:
☐ **Specialty Visit** – Reason:

Visit Results			
Age - Years:	Months:	Weeks:	
Height:	Weight:	Head Circumference:	BMI:
Temperature:	Pulse:	Respirations:	Blood Pressure:
Vision Screen			
Right Eye:		Left Eye:	
☐ No glasses ☐ Glasses ☐ Did not bring glasses			
☐ Subjectively normal ☐ Child or youth unable to comply with screening ☐ Refused ☐ Complete eye examination recommended ☐ Not done			

Hearing Screen				
	500Hz	**1000Hz**	**2000Hz**	**4000Hz**
R				
L				
☐ Subjectively normal ☐ Child or youth unable to comply with screening ☐ Refused ☐ Complete audiology examination recommended ☐ Not done				

Procedures or Tests
☐ None ☐ TB screen ☐ Lead screen ☐ Developmental screen ☐ Autism screen
☐ Hemoglobin ☐ PPD ☐ Blood lead test ☐ Other (list):

Child's Name:	
DOB:	
PID:	
Caregiver:	
Appointment Date:	
☐ After-care summary is attached to this form.	

Vaccines

Children and youth are prohibited from receiving vaccinations at the 3-Day Medical Exam unless an emergency situation requires tetanus vaccination, or if the provider gets direct consent from the biological parent(s).

☐ None Administered

☐ DTap ☐ Tdap ☐ HIB ☐ PCV ☐ Td ☐ MMR ☐ Varicella ☐ Hep A ☐ Hep B

☐ HPV ☐ MenA ☐ MenB ☐ Rotavirus ☐ Influenza ☐ PCV13 ☐ PPSV23 ☐ IPV

☐ Other (list):

Diagnoses

New Medications

Medication:	Dosage:	Prescribed for:

Referrals

☐ None Necessary ☐ ECI (Early Childhood Intervention) ☐ Speech Therapy

☐ Occupational Therapy ☐ Physical Therapy ☐ Specialist (Type):

☐ Other (Type):

Follow-Up

☐ None Necessary

☐ Return Visit: When and Why:

Provider Comments:

Provider Information

Provider Name:	Clinic Name:
Clinic Address:	Clinic Phone:
Provider Signature:	Date:
Caregiver Signature if Provider is unable to sign:	