



CONCHO VALLEY COUNCIL OF GOVERNMENTS



CVCOG RURAL HEAD START
325-944-9666

SAISD HEAD START/
EARLY HEAD START
325-947-3838

Health and Developmental Initial Follow-up Plan

Person Completing this form		Date	
Center	Room #		
Child's Name	D.O.B.		
Parent/Guardian's Name		Phone #	
Medicaid	Private Insurance	Other, Specify	
Type of Follow-up Needed (check only one)			
PHYSICAL	DENTAL	DEVELOPMENTAL	
VISION	HCT/HGB	LEAD	
HEARING	BMI	HEIGHT	
MENTAL HEALTH	WEIGHT	SPECIAL DIET	
IEP/IFSP	TUBERCULOSIS	SPEECH	
ASTHMA	OTHER		
Explain Reason for Follow-up or Referral			
Staff Signature	Date		
Record, in Detail, Initial Conversation with Parent/Guardian (What will be done, when, where, how, who, etc?)			
Parent/Guardian Signature		Date	
Referral Initiated	YES	NO	Date of Referral
Referral to: (Name/Agency)			
Address			
Address			
Telephone #			
COMPLETE		INCOMPLETE	
Date of next follow-up meeting and with whom, if not complete.			