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**HEALTH AND WELLNESS**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_

Has this child received any of the following screenings?

* Well Child Check Yes / No Date \_\_\_\_\_\_\_\_\_\_
* Vision Screening Yes / No Date \_\_\_\_\_\_\_\_\_\_
* Hearing Screening Yes / No Date \_\_\_\_\_\_\_\_\_\_
* Dental Check-Up Yes / No Date \_\_\_\_\_\_\_\_\_\_
* Parent’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

if resource list was provided for screenings that have not been received.