Orange County Head Start, Inc.

Early Childhood Development and Health Services

Antepartum Physician's Report (Early Head Start)

Participant's Name _____ Date of Birth _____

Home Educator _____ Trimester Enrolled _____

Medical Plan _____

Utilizing this form, please provide up-to-date information on the participant referenced above.

Exchange of Information/Intercambio de Información

As the participant referenced above, I hereby authorize the release of the information contained in this document to be provided to Orange County Head Start, Inc.

Como la persona identificada en este formulario, yo autorizo el intercambio de información médica que se encuentra en este documento a Orange County Head Start, Inc.

Parent Signature/*Firma de padre* _____ Date/*Fecha* _____

For Provider Use Only

Date of Exam: _____ **Trimester (please mark one):** ☐ **1st** ☐ **2nd** ☐ **3rd**

Month of Visit (please mark one): ☐ **1 month** ☐ **2 month** ☐ **3 month** ☐ **4 month** ☐ **5 month** ☐ **6 month** ☐ **7 month** ☐ **8 month** ☐ **9 month**

Expected Delivery Date: _____ **High Risk Pregnancy:** ☐ **Yes** ☐ **No**

Education Provided

- ☐ Fetal Development
- ☐ Benefits of Breastfeeding
- ☐ Nutrition of Pregnant Woman
- ☐ Mental Health Interventions
- ☐ Substance Abuse

Explain any abnormal findings/statement of health (if applicable) ☐ No Concerns

- ☐ Anemia
- ☐ Bleeding
- ☐ Diabetes/Pregnancy Induced Diabetes (Gestational)
- ☐ Fatigue
- ☐ Headache
- ☐ Hypertension/ Pregnancy Induced Hypertension
- ☐ Miscarriage
- ☐ Neonatal Death
- ☐ Pain
- ☐ Pre-Term Labor
- ☐ Fetal Development
- ☐ Benefits of Breastfeeding
- ☐ Sickle Cell
- ☐ Swelling

Referrals (if applicable)

To: _____

_____

_____

For: _____

_____

_____

Instructions Provided (if applicable)

_____

_____

_____

_____

_____

_____

Physician's Information

Stamp or Handwritten:

Name: _____ Signature _____

Address: _____

Phone #: _____ Fax #: _____