



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/ Trao đổi thông tin Sức khỏe

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.

Là người tham gia nói trên, tôi bằng lòng cung cấp những thông tin sức khỏe trong văn bản này cho cơ quan Quận Cam Head Start, Inc.

Parent Signature/ Phụ Huynh Ký tên _____ Date/ Ngày _____

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 #: _____