Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

Newborn Health Visit

Date: _____

Baby's Name: _____ DOB:_____ Gender:_____

Mother's Name: _____

Baby's Doctor/Clinic: _____

Weight at Birth: _____ Length At Birth:_____

Gestational Age (#weeks): _____ ☐ Instructed Umbilical Care: _____

Length of Labor: _____ ☐ Vaginal ☐ C-Section _____

Did you have your baby in the Hospital: ☐ Yes ☐ No If No, Where:_____

☐ Incision Care: _____

Any problems at birth? ☐ Jaundice ☐ Apnea ☐ Infection ☐ Other: _____
Notes: _____

Are you: ☐ Breastfeeding ☐ Bottle Feeding How often: _____
☐ At least 8-12/24 ☐ At least 14-31oz/24hrs

☐ Information Given for Storage/Handling Breast Milk Notes:
_____

☐ Maternal Nutrition Discussed ☐ Continue PN Vitamins, Increase Fluids, Balanced Diet ☐ Handouts Given

Baby's Next Doctor Appt: _____ Mother's Next Doctor Appt: _____

Planned Method of BC: _____ Provided Health Education: ☐ Yes ☐ No

Do you have a car seat? ☐ Yes ☐ No

☐ Provided health education SIDS/Importance of Back Sleeping Notes: _____

Where does your baby sleep? __ parents room __ nursery ___sibling's room __ other: please indicate _____

☐ Provided health education post-partum depression/baby blues Notes: _____

☐ Provided information on when to call the Doctor Notes: _____

Do you have help/support easily available: ☐ Yes ☐ No Notes: _____
Notes:_____

Are you currently using any medication (OTC, prescriptions, herbs, street drugs, alcohol)?
List: _____

Do you feel safe in your home? ☐ Yes ☐ No
Referrals/Concerns: _____

_____ _____
Designated Health Staff Signature Date