

2026 Farmworker Outreach Health Assessment - Peds (0-11)		ORW:	Date:
Optional	FHASES ID: _____ Cohort: _____ Employer: _____		
Privacy	<p>My signature indicates that I understand that my child's privacy will be protected within this farmworker health network except in the following circumstances: if harm is suspected of a minor, elderly, or disabled person.</p> <p>Signature of parent or legal guardian: _____</p>		
Demographics	<p>Name (first, last): _____ Birth date: ____/____/____ <input type="checkbox"/> Est. mm/dd/yyyy</p> <p>Preferred language: Span/ Eng/ Other: _____ Do you need an interpreter? Yes/ No</p> <p>Worker type: Migratory / Seasonal / Other (If migrant) Estimated departure date: _____</p> <p>Parent or legal guardian: _____</p> <p>Is your child of Hispanic, Latino, or Spanish origin? Mark all that apply.</p> <p><input type="checkbox"/> Yes, Mexican, Mexican Am., Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, another Hispanic, Latino, or Spanish origin <input type="checkbox"/> No, not of Hispanic, Latino, or Spanish origin <input type="checkbox"/> Decline to answer</p> <p>What is your child's race? Mark all that apply.</p> <p><input type="checkbox"/> White <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African Am. <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Some other race <input type="checkbox"/> Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Decline to answer <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander</p> <p>What sex was your child assigned at birth? Male/ Female</p> <p>Housing: Own/ Rent/ Grower-provided/ Homeless</p> <p>Address: _____ City: _____</p> <p>State: _____ Zip code: _____ County: _____</p> <p>Health insurance: None / Medicaid / Medicare / Health Choice / Private Family income (\$ amount): _____</p> <p>Amount is per: week / 2 weeks/ month / year # months worked ____ # family members: _____</p>		
Communication	<p>How can we communicate with you? Ask parent to initial next to each below if OK.</p> <p>Cell number: _____ Parent/guardian full name: _____</p> <p>_____ It's ok to leave a message. _____ It's ok to leave a voicemail. _____ It's ok to send a text message (SMS) even though total privacy is not guaranteed. _____ It's ok to send a WhatsApp message even though total privacy is not guaranteed. _____ OK to send a message through WhatsApp even though it may not be completely private. WhatsApp number (if different): _____</p> <p>Which communication method do you prefer? Mark preference.</p>		
Gov't Services	<p>If 0-5, enrolled in WIC? No/ Yes Enrolled in Migrant Head Start? No/ Yes/ None available</p> <p>If 5-12, enrolled in school? No/ Yes Referral: <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined</p>		
General Health	<p>Do you have any concerns about your child's health? No/ Yes: _____</p> <p><i>(If yes) How can I help you with this concern?</i> _____</p> <p>Has your child been diagnosed with any medical conditions? No/ Yes: _____</p> <p>Is your child taking (or should they be taking) any medications? No/ Yes: _____</p>		

General Health cont.	<p>Has your child had a physical exam, during which vaccines were administered...No/Yes <i>(For children <1 years old) ...in the last 3 months?</i> <i>(For children 1 to 2 years old) ...in the last 6 months?</i> <i>Offer referral if not up-to-date</i> <i>(For children >2 years old) ...in the last 12 months?</i></p> <p>Referral: <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined <i>Diabetes, HIV, TB or other chronic condition, consider MCN</i></p>
Dental	<p>Has your child had a dental appointment in the last 12 months (if 6 months or older)? No/ Yes <i>Offer referral to dentist if "no".</i> Has your child received dental sealants? (plastic coatings that are applied to the surfaces of the teeth to prevent cavities) No/ Yes <i>Offer referral to dentist if "no".</i></p> <p>Referral: <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined</p>
Safety	<p><i>For children 0 to 4 years old: Does your child use a car seat when riding in the car? No/ Yes</i> <i>For children 5 to 8 years old: Does your child use a booster seat when riding in the car? No/ Yes</i> <i>For children 9 to 11 years old: Does your child wear a seat belt when riding in the car? No/ Yes</i></p> <p>Referral: <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined Health ed: <input type="checkbox"/> Provided <input type="checkbox"/> Follow up</p>
CM	<p>Do you have any other questions or concerns? No/ Yes: _____</p> <p>Referral: <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined</p>
Addtl. Health Ed	<p>What health topics would you like more information about? <i>Circle those desired and check off if provided.</i></p> <p><input type="checkbox"/> Car seats <input type="checkbox"/> Nutrition <input type="checkbox"/> Other: _____ <input type="checkbox"/> Seat belts <input type="checkbox"/> Weight <input type="checkbox"/> Dental health <input type="checkbox"/> COVID-19</p>
Notes	