H-309

Early Head Start
Newborn Welcome Visit

Mother's Name: ____

Father's Name: ____

Infant's Name: ____

DOB ____/____/____

Breast or bottle fed? ______________________

Information Shared with Family

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____

Medical Information

Family Doctor: ____

Pediatrician: ____

Dentist: ____

________________________________ ___/___/___
Staff Signature Date

_________________________________ ___/___/___
Parent Signature Date