

COMMUNITY ACTION TEAM, INC.
CHILD AND FAMILY DEVELOPMENT PROGRAMS
Early Head Start Home Visit Form

Home Visit Number: _____ Date: _____

Child's Name: _____

Time of Arrival: _____ Time of Departure: _____ Length of Visit: _____

Location of visit if not in home: _____

People Present: _____

INFORMATION SHARED/DISCUSSED			
FAMILY	HEALTH AND SAFETY	EDUCATION	
Form 3-11 Updates	Child Safety	School Readiness Goals	
Family Partnership Goals, New and Updates	Medical	TS Gold (Progress Checkpoints & Observations)	
Community Events/Resources	Dental	Child Goals	
Parent Meetings	Mental Health	PBIS	
Policy Council	Nutrition	Ready Rosie	
Parenting Education	Hearing/Vision	PAT Curriculum Sharing	
Adult Education/Training	Care Plans		
Self-sufficiency goals	ASQ Screenings		
Child Custody Issues	Tobacco Cessation		

Progress on family goal: _____

Progress on child's health status: _____

Progress on child's goals: _____

Home Visit Summary: _____

Plan for Next Home Visit: _____

Parent/Guardian Signature(s): _____

Home Visitor Signature: _____