

**REFERRAL:**

Medical \_\_\_\_

Dental \_\_\_\_

Vision \_\_\_\_

OBGYN \_\_\_\_

Psych \_\_\_\_

Other \_\_\_\_

****

**REGISTRO MÉDICO para Niños**

**Chequeo de Salud Bàsica**

**Escuela Oficial Rural Mixta, Tipo Minimo, Aldea San Felipe de Jesus**

**6 de Mayo, 2019**

**HISTORIAL MÉDICO**

Nombre del Paciente (Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\***Teléfono: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fecha de Nacimiento (Date of birth): \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ (dd/mm/yy) Edad (Age) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexo (Gender): Masculino (Male) \_\_\_\_\_\_\_ Femenino (Female) \_\_\_\_\_\_\_ Grado Escolar (Grade): \_\_\_\_\_\_\_\_

Nombre de la madre o padre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SALUD INFORMACIÒN**:

Peso (Weight) \_\_\_\_\_\_\_\_\_Kg. Talla (Height) \_\_\_\_\_\_\_\_cms.

Frecuencia Respiratoria (Respiratory Rate) \_\_\_\_\_\_\_ / min.

Pulso (Pulse)\_\_\_\_\_\_\_\_\_ / min.

Piel (skin) ¿Problemas observadas? Si (yes) / No (no) (Referir condiciones sin normal)

Dientes (teeth) cavidades detectado? Sí (yes) / No (no) Si es si, referir. (If yes, refer)

El barniz de fluoruro aplicado (Fluoride varnish applied)? Si (yes) / No (no)

Signature of person that applied fluoride: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Albendazol (Albendazole): Sí (yes) / No (no)

Signature of person administering medication: NO SE DARA DESPARASITANTE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problemas o Preocupaciones (Problems or Concerns) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERIDO (REFERRED)**

Motivo de referencia (Reason for referral) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Firma de la persona médica:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_