Copy given to_____caregiver on____/____/_____by_____

Copy given to_____physician on_____/____/_____by_____

## CHILD HEALTH STATUS COMPONENT

Child's Name_____ Date of Birth__/__/__ Sex___ Race/Eth._____
Completed by_____ Assessment Date __/__/__ Update __/___/___
County _____

### INSURANCE INFORMATION

Medicaid ____ Health Choice ____ Other Insurance Company _____
Policy/ID Number _____

| **Current Primary Physician** | **Current Dentist** |
|---|---|
| Name _____ | Name_____ |
| Address_____ | Address_____ |
| _____ | _____ |
| Telephone (  )_____ | (  )_____ |
| Date of last physical exam _____ | Date of last dental exam _____ |

Previous medical/dental providers
Name_____ Specialty_____ Telephone (  )_____
Name_____ Specialty _____ Telephone (  )_____
Name_____ Specialty _____ Telephone (  )_____

### CHILD'S MEDICAL HISTORY

Allergies/Drug Sensitivities _____
_____
Surgery/hospitalizations_____
_____
Injuries_____
Communicable Diseases_____
_____
Current medical problems _____
_____
Developmental/learning problems_____
_____
Significant behavioral problems _____
_____
Has DEC evaluation been done? Yes ____ No _____ Date of evaluation _____
Diagnosed mental disorder/emotional Illness_____
_____
Glasses/contacts required? Yes ____ No ____ Hearing aid required? Yes ___ No ___
Current dental problems _____
_____
Special dietary needs _____
_____

| **Current medications** | **Dosage** | **Why prescribed** |
|---|---|---|
| 1)_____ | | |
| 2)_____ | | |
| 3)_____ | | |
| 4)_____ | | |

Copy given to_____ caregiver on_____(date) by_____
Copy given to _____ physician on _____(date) by_____

**CHILD HEALTH STATUS COMPONENT**

**IMMUNIZATION RECORD: (Attach copy of record if available, otherwise complete the following to the extent possible)**

| Immunization | Recommended Frequency | Last received | Current? Y/N/NA |
|---|---|---|---|
| Diptheria, Tetanus, Pertussis-1 | | | |
| Diphtheria, Tetanus, Pertussis-2 | | | |
| Diphtheria, Tetanus, Pertussis-3 | | | |
| Diphtheria, Tetanus, Pertussis-5 | | | |
| Diphtheria, Tetanus, Pertussis-5 | | | |
| Hib DTP-Haemophilius influenzae type B | | | |
| Polio (IPV or OPV) | | | |
| HBIG (Hepatitis B Immune Globulin) | | | |
| Hb-Hepatitis B Vaccine | | | |
| MMR-Measles, Mumps, Rubella | | | |
| Varicella- Chickenpox | | | |
| Td- Tetanus, Diphtheria | | | |
| Other: | | | |
| | | | |

BIRTH FAMILY HISTORY- (use additional sheets as needed)

Biological mother

Current health status

Biological father

Current health status

Biological siblings

History of family violence? Yes__ No__
Family history of alcohol or drug abuse? Yes__ No__
Genetic Disorders? Yes __ No__ Describe:

**OTHER RELEVANT HEALTH INFORMATION**