

PATIENT MEDICAL INFORMATION -CHILD (In Applicant's Home)

TO THE EXAMINING PHYSICIAN	The applicant below is a child -living in a home considering the placement of a child. The Department of Social Services needs information on his/her physical and mental health, and the extent and significance of any health condition that may relate to his/her presence in the home.
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CHILD'S FULL NAME	DATE OF BIRTH	HOW LONG PHYSICIAN HAS KNOWN APPLICANT
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I. PHYSICAL EXAMINATION

Height	Weight	Temperature	Pulse	Blood Pressure	Respiration Rate	Vision	Hearing
Lungs				Heart			
Allergies:							
Nervous System				Endocrine			

LIST CURRENT PRESCRIBED MEDICATIONS:

II. LABORATORY TESTS (list tests and results)

Date	Result
Tuberculin Test	
Chest X-Ray	

III Are immunizations up to date? YES NO If no, please check appropriate box to describe medical contraindication. The above child has a valid medical contraindication to being vaccinated at this time. This is a permanent condition OR Temporary condition until ___/___/___

IV. GENERAL HEALTH: (attach additional pages as needed)
 DOES THE PATIENT HAVE THE USUAL LIFE EXPECTANCY?

 DOES THE PATIENT HAVE A CHRONIC OR ACUTE DISEASE?

 DOES THE PATIENT HAVE A CHRONIC DISEASE, A BEHAVIORAL CONDITION OR ANY DISABILITY THAT MAY AFFECT THE WELL-BEING OF A FOSTER OR ADOPTIVE CHILD IN THE HOME?

 WAS ANY RECOMMENDATION FOR MEDICAL CARE MADE TO THE PATIENT? (IF YES, EXPLAIN)

5. HAS THE PATIENT BEEN TREATED OR HOSPITALIZED FOR ANY OF THE FOLLOWING :(explain)

<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DRUG/SUBSTANCE ABUSE
<input type="checkbox"/> DEPRESSIO	<input type="checkbox"/> BI-POLAR DISORDER
<input type="checkbox"/> SUICIDE ATTEMPTS	<input type="checkbox"/> PSYCHOSIS
<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> OTHER (explain)

V. Additional Comments:

PHYSICIANS SIGNATURE	DATE OF EXAM	RETURN COMPLETED FORM TO:	
PHYSICIANS NAME (Print or Type)			
Address (Include City, State, Zip Code)			

PATIENT MEDIAL INFORMATION CHILD

FULL NAME	BIRTHDATE
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BRIEFLY DESCRIBE AND GIVE APPROXIMATE DATES FOR THE FOLLOWING:

MAJOR ILLNESSES:

HOSPITALIZATIONS:

SURGERY:

ACCIDENTS:

PSYCHIATRIC/MENTAL HEALTH TREATMENT:

ALCOHOL/DRUG TREATMENT:

FAMILY MEDICAL HISTORY - IS THERE A HISTORY OF:

	YES	NO		YES	NO		YES	NO
ALLERGIES			ALCOHOL/DRUG USE			ANEMIA		
DIABETES			MENTAL ILLNESS/RETARDATION			OTHER (specify)		
HEART DISEASE			HYPERTENTION					
CANCER			LUNG DISEASE					

DESCRIBE THE CHILD'S GENERAL HEALTH CONDITION & LIST ANY CURRENT MEDICATIONS:

IS THE CHILD CURRENTLY RECEIVING ANY TREATMENT, THERAPY OR REHABILITATION FOR MEDICAL OR MENTAL HEALTH PROBLEMS? YES NO (If yes, please provide name, address, and telephone number of provider)

DOES THE CHILD HAVE ANY PHYSICAL OR BEHAVIORAL DISABILITIES OR SPECIAL NEEDS (if yes, please describe)