Department of
Children's Services

Child's Medical Record

Last Name: **First Name:** **Date of Birth:**

Social Security #: **Sex:** **Race:**

Father's Name: **Mother's Name:**

Street Address:

City: **State:** **Zip Code:**

Immunizations

Are immunizations up to date? Yes No Is a copy of immunization records available? Yes No

Medical

Name of medical provider: Date of last physical:

Mental Health

Has the child ever been treated or hospitalized for mental illness or suicide thoughts/attempts? Yes No

If yes, list dates and hospital:

Does the child have a current or past history of drug or alcohol abuse? Yes No

If yes, please explain:
(What? When?)

Was treatment received? Yes No

If yes, please explain
(What? When? Where?)

TB Risk Assessment

Date: Results:

And / or TB (PPD) Not at Risk Low Risk

Date: Results:

Special Needs or Disabilities:

Current Medial Problems:

Current Medications:

Comments:

Physician/NP/PA Name:

Physician/NP/PA Signature: Date:

Instructions for Use of Form

The resource parent and a licensed health care provider complete this form.

1. Fill in demographic data.

2. Check the appropriate box if immunizations are up-to-date and whether an immunization record is available for review. If a child is not receiving immunizations, an explanation should be included.

3. List the regular medical health care provider of the child including date of the last visit to that provider.

4. List any hospitalizations for mental health issues or suicide thoughts or suicide attempts including dates of hospitalizations and treatments received.

5. Information regarding the child's drug/alcohol history must be completed.

6. The health care provider completes the TB information. If a risk assessment is done and the results show no or low risk, a TB skin test is not required and can be left blank.

7. List any special needs or disabilities that affect the daily activities of the child. This can include movement disorders requiring mobility aids, special sense issues such as loss of hearing or sight, respiratory problems requiring breathing treatments or oxygen, autistic spectrum disorders, etc.

8. List any current medical problems that have been diagnosed or treated by the health care provider.

9. Comment section is for the health care provider to add any additional information that may be pertinent to the Department regarding the ability of the family to be a resource/adoptive home.

10. Lastly, the health care provider shall print their name, sign and date the form.