**Health Passport (HPP)**

**This HPP is to be completed for each child in care within four weeks of placement. It is to be kept with the child while in care and accompanies the child when the child is returned home, placed in a permanent placement or when the child is emancipated from care. The HPP documents should be photocopies periodically and the copies kept in the case file.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last** | **First** | **MI** | **State ID/Medicaid #** |

|  |  |
| --- | --- |
| **Date of Birth** | **Male/Female** |

**Identifying Information Date Opened**

|  |  |
| --- | --- |
| **Height:** | **Weight:** |
| **Eye Color:** | **Scars/Identifying Marks:** |
| **Hair Color:** | **Other:** |

**-- CHILD’S CHRONIC HEALTH PROBLEMS HISTORY --**

**History of Chronic Health Problems (check all that apply and date diagnosed, if known)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ear Infections** |  |  | **Asthma** |  |  |
| **Diabetes** |  |  | **ADHD/ADD** |  |  |
| **Urinary** |  |  | **Heart Problems** |  |  |
| **Epilepsy** |  |  | **Sickle Cell** |  |  |
| **Other Seizure Disorders** |  |  | **Positive TB Skin Test** |  |  |
| **Bone/Joint Problems** |  |  | **Other** |  |  |

|  |  |  |
| --- | --- | --- |
| **Medical Alert/Allergies** | **Known Reactions/Symptoms** | **Emergency Response** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Copy of immunization record must be attached to the health passport, Allergies & Medical Alert Conditions. (To be completed by caseworker and given To provider within 30 days of PLACEMENT).**

**-- CHILD’S MEDICAL HISTORY --**

**To be completed by caseworker and given to provider**

|  |  |  |
| --- | --- | --- |
| **Name of Hospital at Birth:** | **Hospital Address:** | **Hospital City, State, Zip** |
| **Birth Weight:** | **Problems with Pregnancy** | **Problems with Birth:** |

**CHILDHOOD DISEASES (if known, list age at time of illness)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Chicken Pox** |  | **Age:** | **Details:** |
| **Measles** |  | **Age:** | **Details:** |
| **Rubella** |  | **Age:** | **Details:** |
| **Mumps** |  | **Age:** | **Details:** |
| **Other:** |  | **Age:** | **Details:** |

**MEDICAL/DEVELOPMENTAL HISTORY AND PROBLEMS**

|  |  |  |
| --- | --- | --- |
| **Motor** |  | **Details:** |
| **Language** |  | **Details:** |
| **Developmental/Cognitive** |  | **Details:** |
| **Menstrual/Contraceptive History** |  | **Details:** |

**BIOLOGICAL FAMILY HISTORY** (Please check box if anyone in child’s biological family has been diagnosed or suffered from any of the following. List relation to child. MOC (bio-mother); FOC (bio-father). Use the abbreviations M=Maternal, P=Paternal (i.e., M-grandmother for maternal grandmother; P-uncle for paternal uncle, etc.)

**Who/Relation to Child**

|  |  |  |
| --- | --- | --- |
| **Diabetes** |  |  |
| **Developmental Disabilities** |  |  |
| **Epilepsy/Seizures** |  |  |
| **Kidney Problems** |  |  |
| **High Blood Pressure** |  |  |
| **Mental Health Issues** |  |  |
| **Heart Attack/Stroke (under age 60)** |  |  |
| **Positive TB Skin Test** |  |  |
| **Blood Disease or Anemia** |  |  |
| **Birth Defects** |  |  |
| **Cancer** |  |  |
| **Death at young age** |  |  |
| **Stomach/Intestinal Problems** |  |  |
| **Asthma** |  |  |
| **Hepatitis C** |  |  |
| **Sickle Cell** |  |  |
| **HIV/AIDS** |  |  |
| **Substance Abuse** |  |  |
| **Other:** |  |  |

**Additional Medical history of biological family and/or comments:**

|  |
| --- |
|  |

**MEDICAL APPOINTMENTS/HOSPITALIZATIONS:**

|  |  |  |
| --- | --- | --- |
| **Doctor:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Physical** |  |  |
| **Checkup** |  |  |
| **Illness** |  |  |
| **Hospitalization** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Current medications child is taking:**

**Additional comments:**

**Referrals:**

|  |  |  |
| --- | --- | --- |
| **Doctor:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Physical** |  |  |
| **Checkup** |  |  |
| **Illness** |  |  |
| **Hospitalization** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Current medications child is taking:**

**Additional comments:**

**Referrals:**

|  |  |  |
| --- | --- | --- |
| **Doctor:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Physical** |  |  |
| **Checkup** |  |  |
| **Illness** |  |  |
| **Hospitalization** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Current medications child is taking:**

**Additional comments:**

**Referrals:**

|  |  |  |
| --- | --- | --- |
| **Doctor:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Physical** |  |  |
| **Checkup** |  |  |
| **Illness** |  |  |
| **Hospitalization** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Current medications child is taking:**

**Additional comments:**

**Referrals:**

**DENTAL APPOINTMENTS:**

|  |  |  |
| --- | --- | --- |
| **Dentist:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Cleaning** |  |  |
| **Checkup** |  |  |
| **Cavity** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Additional comments:**

**Referrals:**

|  |  |  |
| --- | --- | --- |
| **Dentist:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Cleaning** |  |  |
| **Checkup** |  |  |
| **Cavity** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Additional comments:**

**Referrals:**

|  |  |  |
| --- | --- | --- |
| **Dentist:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Cleaning** |  |  |
| **Checkup** |  |  |
| **Cavity** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Additional comments:**

**Referrals:**

|  |  |  |
| --- | --- | --- |
| **Dentist:** | **Date appt scheduled:** | **Date of appt:** |

**Reason for appointment:       Details**

|  |  |  |
| --- | --- | --- |
| **Cleaning** |  |  |
| **Checkup** |  |  |
| **Cavity** |  |  |
| **Injury** |  |  |
| **Other: (specify)** |  |  |

**Diagnosis/Outcome:**

**Prescriptions/Instructions:**

**Additional comments:**

**Referrals:**

**MEDICATIONS (Past & Present):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication:** | **Condition:** | | **Dosage:** |
| **Date began taking medication:** | | **Date stopped taking medication:** | |
| **Reactions/outcome/comments:** | | | |
| **Prescribing Doctor:** | | | |

**GENERAL PRACTIONERS:**

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

**DENTISTS:**

|  |
| --- |
| **Dentist Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Dentist Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

**SPECIALISTS/OTHER MEDICAL PROFESSIONALS:**

|  |
| --- |
| **Physician/Specialist Name:** |
| **Specialty:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician/Specialist Name:** |
| **Specialty:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician/Specialist Name:** |
| **Specialty:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician/Specialist Name:** |
| **Specialty:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Physician/Specialist Name:** |
| **Specialty:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

**PSYCHOLOGISTS/PSYCHIATRISTS/LICENSED MENTAL HEALTH PROFESSIONALS:**

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

|  |
| --- |
| **Name:** |
| **Address:** |
| **City, State, Zip:** |
| **Phone/Fax:** |
| **Date first saw child:** |

**-- CHILD’S EDUCATIONAL HISTORY –**

**All grades from preschool on**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Grade** | **Year** | **Name of School/District** | **Individual Education Plan (date/type of disability)** | **Comments** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Revised 06/06