



BASIC HEALTH INFORMATION

NAME OF CHILD			DATE OF BIRTH
NAME AND PHONE NUMBER OF PCP			
DATE OF LAST DR. VISIT	REASON FOR VISIT	DATE OF NEXT SCHEDULED DR. VISIT	REASON FOR VISIT
NAME AND PHONE NUMBER OF DENTIST			
DATE OF LAST VISIT	REASON FOR VISIT	DATE OF NEXT VISIT	REASON FOR VISIT
NAME OF PHYSICAL HEALTH MCO			
DOES THE CHILD RECEIVE MEDICAL ASSISTANCE?		IF YES, RECIPIENT #	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
DOES THE CHILD HAVE OTHER HEALTH CARE INSURANCE?		IF YES, LIST PLAN	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
ARE IMMUNIZATIONS CURRENT AS PER AAP PERIODICITY SCHEDULE?		DATE OF NEXT IMMUNIZATION VISIT	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
CURRENT MEDICATION(S) & PURPOSE			
NAME AND PHONE NUMBER OF PHARMACY			
IS CHILD FOLLOWED BY A PCP OR SPECIALIST FOR ANY CHRONIC OR PRESENT CONDITIONS?			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, BRIEFLY DESCRIBE CONDITION. IF SPECIALIST IS NOT PCP, PLEASE LIST NAME AND PHONE NUMBER			
LIST ANY FOOD, MEDICATION, ENVIRONMENTAL ALLERGIES			
IS THE CHILD RECEIVING (check all that apply):		NAME AND PHONE NUMBER OF SERVICE PROVIDER/CLINICIAN/THERAPIST	
<input type="checkbox"/> Behavioral Health Services <input type="checkbox"/> Intellectual Disability Services			
IS THE CHILD RECEIVING (check all that apply):		NAME AND PHONE NUMBER OF PROVIDER	
<input type="checkbox"/> Speech Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy			
DOES THE CHILD RELY ON THE USE OF EYE GLASSES, HEARING AIDS, OR OTHER SPECIAL EQUIPMENT (check all that apply)?			
<input type="checkbox"/> Eye Glasses <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Orthodontia Appliances <input type="checkbox"/> Wheelchair <input type="checkbox"/> Oxygen <input type="checkbox"/> Other			
PLEASE DESCRIBE		MEDICAL EQUIPMENT PROVIDER AND PHONE NUMBER	
NAME AND PHONE NUMBER OF EYE DOCTOR			