AGAPE Child Medical Record

Last Name _____ First Name _____

Date of Birth _____ Sex _____ Race _____

Father's Name _____ Mother's Name _____

Street Address _____

City _____ State _____ Zip Code _____

IMMUNIZATIONS

Are immunizations up to date: ☐ Yes ☐ No Copy of record available? ☐ Yes ☐ No

Is child free of communicable disease? ☐ Yes ☐ No * please attach immunization record

MEDICAL

Name of medical provider _____ Date of last physical _____

MENTAL HEALTH

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

If yes, list dates and hospital _____

Does the child participate in counseling/therapy services? ☐ Yes ☐ No

If yes, please explain. _____

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

If yes, please explain. _____

Was treatment received? ☐ Yes ☐ No

If yes, please explain. _____

TB Risk Assessment

and/or OTB (PPD) ☐ Not at Risk ☐ Low Risk Date/Results _____

Special Needs or Disabilities _____

Current Medical Problems _____

Current Medications _____

Comments _____

Physician/NP/PA name _____

Physician/NP/PA Signature _____ Date _____