FCL 055

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KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Foster Care and Residential Facility Licensing Division
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License #_____

HEALTH CHECKLIST FOR EMERGENCY/TEMPORARY CARE

Name _____Date_____

Facility _____Interviewer _____

1. Are you having any health problems at the present time? ☐ Yes ☐ No

Describe_____

2. Have you had any of the following problems in the past 24 hours?

	YES	NO		YES	NO		YES	NO
Sore Throat			Nausea/Vomiting			Diarrhea		
Earache			Headache			Abdominal Pain		
Swollen Glands			Skin Rash			Kidney/Urinary		
Fever/Chills			Drug Reaction					

3. Do you have any medical problems such as:

	YES	NO		YES	NO		YES	NO
Heart Problems			Diabetes			Seizures/Convulsions		
Physical Disability			Asthma			Other		

If other please explain_____

4. Do you think you have an infectious/communicable disease such as:

	YES	NO		YES	NO
Hepatitis/Liver Problem			Sexually Transmitted Disease (STD/VD)		
Mononucleosis			Other		

Please explain_____

5. Why do you think this?_____

6. Do you think you have been exposed to any communicable disease in the past 2-3 weeks? ☐ Yes ☐ No

Why do you think this? _____

7. Are you taking any kind of medication or shots? ☐ Yes ☐ No

If Yes, What kind? What for? _____ Name/Address of physician who ordered it_____

8. Are you allergic to anything like aspirin, foods, medicine, etc.? ☐ Yes ☐ No

Specify _____

What happens? _____

9. For girls only: Do you take birth control pills? ☐ Yes ☐ No

If yes, when did you take your last pill? _____

License #_____

Child Name_____

Date of last menstrual period _____

10. Have you ever tried to hurt yourself or others, or thought about or attempted to commit suicide? ☐ Yes ☐ No

    If yes, when and how?_____

11. Have you used any street drugs? ☐ Yes ☐ No

    If yes, what kind and when?_____

12. Are you currently sexually active? ☐ Yes ☐ No

    Do you use any method of birth control or any protection?_____

13. Name/address of your family doctor _____

    Approximate date of last visit _____

Record any observations such as personal appearance, mannerisms, ability to answer questions, indications that the youth may be using drugs, is suicidal, etc. Sign each note with professional signature.

Date	Progress Notes

14. Medical care is needed? ☐ Yes ☐ No

Medical care obtained (date): _____(time) _____

Staff completing form _____ Date_____