

MEDICAL AND GENETIC INFORMATION FOR CHILD
 (Attach Social History)

PART I. MEDICAL HISTORY OF CHILD

1. Name	2. Date of Birth:	3. Social Security #	4. Birthplace (Hospital and Town):	5. Time of Birth:	
6. Apgar Score 1 min. 5 min.	7. Premature (mos/wks)	8. Weight at Birth	9. Length at Birth		
10. Type of Delivery	11. Duration of Labor	12. Breast Fed?	13. Formula?		
14. Name & Address of Attending Physician: (Attach copy of records or authorized release.)		15. Complications of Pregnancy/Birth: (Include any birth injury to child.)			
16. Medications Given: (From Birth until Placement)					
17. Birth Defects: (Specify)					
18. Immunization History: (Attach copy of child's immunization records.)					
19. Dates of Significant Illnesses or Hospitalizations: (Specify type of illness, name & address of physician and or hospital. Attach records or authorized release.)					
20. Does this child have any significant growth or development problems?					
21. Does this child have any chronic health conditions?					
22. Does this child suffer from any serious emotional and/or behavior problems? If yes, indicate test results, diagnoses, and names & addresses of therapists.					
23. Does this child have significant learning disabilities?					
24. Does this child have affiliation with a Native American tribe? If yes, provide the name of the tribe.					
25. Medical Conditions: (Describe on separate sheet)					
	Allergies/Asthma	Down's Syndrome	Growth problems	Sickle Cell Anemia	
	Anemia	Drug usage/dependence	HIV/AIDS	Spina Bifida	
	Anorexia/Bulimia	Epilepsy	Kidney condition	Vision condition/blind	
	Cancer	Hearing condition/deaf	Intellectual/Dev. Disability	Other (please specify)	
	Congenital Abnormality	Heart condition	Muscular Condition	Other (please specify)	
	Diabetes	Hepatitis (specify type)	Orthopedic condition	Other (please specify)	
26. Developmental Milestones (Indicate age milestone was accomplished)					
Milestone	Age	Milestone	Age	Milestone	Age
Turned Over		Stood		Toilet Trained	
Sat Alone		Walked		Used Words	
Crawled		Fed Self			

The information I have given above is true and correct to the best of my knowledge. I understand that if at anytime in the future I become aware of any information or conditions which might affect the health, development or physical condition of my child or my child's offspring, I may notify, in writing, the Department for Children and Families, Atten: Prevention and Protection Services, 555 S. Kansas Avenue, Topeka, KS 66603, (785) 296-4653.

Print Name And Relationship to Child : _____ Date: _____ Signed _____

PART II. GENETIC AND MEDICAL HISTORY OF MOTHER

1. Name		2. Date of Birth:		3. Birthplace	
4. Address				5. Social Security #	
6. Medications, drugs, and alcohol used before and during this pregnancy.					
7. Were there any complications or problems during pregnancy or delivery? Explain:					
8. Physical Description: Height		Weight	Eye Color	Hair Color/Texture	Skin Color
9. General Health including hospitalization or surgery.					
10. Check any of the following health conditions which appear in yourself or your family's health background:			For any condition checked, please provide additional information that may be available (such as, type of mental illness, descriptions of congenital defect, which member of family, age at onset, etc. Please attach additional information on a separate sheet of paper.)		
Mother's Mother		Family		Mother's Mother	
				Alcoholism	
				HIV/AIDS	
				Allergies/Asthma	
				Kidney Condition	
				Bipolar Disorder (specify type)	
				Intellectual and Developmental Disability	
				Cancer	
				Muscular Condition	
				Congenital Abnormality	
				Other Mental Illness (please specify)	
				Diabetes	
				Schizophrenia	
				Down's Syndrome	
				Sickle Cell Anemia	
				Drug usage/dependence	
				Sexually Transmitted Disease (please specify)	
				Epilepsy	
				Spina Bifida	
				Hearing problems/deaf	
				Vision problems/blind	
				Heart condition	
				Other (please specify)	
				Hepatitis	
				Other (please specify)	
11. Race and/or Nationality			12. Tribal affiliation: If yes, name of tribe:		13. Religion
14. Occupation & employment history					

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PART III. GENETIC AND MEDICAL HISTORY OF FATHER

1. Name		2. Date of Birth:		3. Birthplace	
4. Address				5. Social Security #	
6. Physical Description: Height	Weight	Eye Color	Hair Color/Texture		Skin Color
7. General Health including hospitalization or surgery.					
8. Check any of the following health conditions which appear in yourself or your family's health background:			For any condition checked, please provide additional information that may be available (such as, type of mental illness, descriptions of congenital defect, which member of family, age at onset, etc. Please attach additional information on a separate sheet of paper.)		
Father's Father		Father's Family		Father's Family	
		Alcoholism		HIV/AIDS	
		Allergies/Asthma		Kidney Condition	
		Bipolar Disorder (specify type)		Intellectual and Developmental Disability	
		Cancer		Muscular Condition	
		Congenital Abnormality		Other Mental Illness (please specify)	
		Diabetes		Schizophrenia	
		Down's Syndrome		Sickle Cell Anemia	
		Drug usage/dependence		Sexually Transmitted Disease (please specify)	
		Epilepsy		Spina Bifida	
		Hearing problems/deaf		Vision problems/blind	
		Heart condition		Other (please specify)	
		Hepatitis		Other (please specify)	
9. Race and/or Nationality		10. Tribal affiliation: If yes, name of tribe:		11. Religion	
12. Occupation & employment history					

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