

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 minute: 5 minutes:	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/ Developmental 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)

<u>Milestone</u>	<u>Age</u>	<u>Milestone</u>	<u>Age</u>	<u>Milestone</u>	<u>Age</u>
Turned Over		Stood		Toilet Trained	
Sat Alone		Walked		Used Words	
Crawled		Fed Self		Other	

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: _____

Relationship to Child: _____

Signature: _____ Date: _____

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's				
Mother Family		Mother		Family		
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Condition	
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder (specify type)	<input type="checkbox"/>	<input type="checkbox"/>	Intellectual and Developmental Disability	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Condition	
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	Other Mental Illness (please specify)	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	
<input type="checkbox"/>	<input type="checkbox"/>	Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	
<input type="checkbox"/>	<input type="checkbox"/>	Drug usage/dependence	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease (please specify)	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems/deaf	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems/blind	
<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	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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Print Name and Relationship to Child: _____

Signature: _____ Date: _____

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
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's			
Father	Family	Father		Family	
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Condition
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder (specify type)	<input type="checkbox"/>	<input type="checkbox"/>	Intellectual and Developmental Disability
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Condition
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	Other Mental Illness (please specify)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Drug usage/dependence	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease (please specify)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems/deaf	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems/blind
<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)
9. Race and/or Nationality		10. Tribal affiliation: If yes, name of tribe:		11. Religion	
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