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|  | **Family Genetic and Medical History** |

Completion of this form is very important to ensure your child receives all necessary medical and mental health services while they are living outside your home. Your medical history as well as any family genetic information will allow for medical and mental health providers to better understand the needs of your child so appropriate care will be provided while in care. Please provide as much information as possible.

Date completed: Click or tap to enter a date.

Child’s Name:  Date of birth:

Name of person completing this form:  What is the relationship to name of child :

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| **Section 1: Birth Mother’s Background and Family Genetic/Medical History** | | | | |
| YEAR OF BIRTH | | RACE | | ETHNICITY |
| HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR | RELIGION |
| LEFT HANDED  RIGHT HANDED | HIGHEST GRADE ACHIEVED | | LEARNING CONCERNS | |
| HOBBIES/INTERESTS/PROFESSION | | | | |

| **BIRTH MOTHER** | **MEDICAL CONDITION (PLEASE PROVIDE SPECIFIC DIAGNOSES IN THE BLANK BOX, IF APPLICABLE)** | **AGE OF ONSET, TREATMENT, MEDICATION** | **RELATIVE/FAMILY MEMBER** | **RELATIONSHIP TO BIRTH MOTHER** | **AGE OF ONSET, TREATMENT, MEDICATION** |
| --- | --- | --- | --- | --- | --- |
|  | Attention Deficit Disorder (ADD)  Attention Deficit Hyperactivity Disorder (ADHD) |  |  |  |  |
|  | Allergic reaction (e.g., food, drugs, animals) |  |  |  |  |
|  | Arthritis |  |  |  |  |
|  | Birth defects |  |  |  |  |
|  | Blood-Borne Pathogen (e.g. HIV, AIDS, Hepatitis B, Hepatitis C)  Yes  No |  |  |  |  |
|  | Blood disorder (e.g., hemophilia, sickle cell anemia) |  |  |  |  |
|  | Cancer |  |  |  |  |
|  | Cardiovascular (e.g., high blood pressure, heart attack, stroke) |  |  |  |  |
|  | Developmental delays (e.g., difficulty with reading, math, writing, understanding directions, Tourette’s syndrome, dyslexia) |  |  |  |  |
|  | Fetal Alcohol Syndrome (FAS)  Fetal Alcohol Effects |  |  |  |  |
|  | Gynecological problems/history (e.g., miscarriage, still birth, neonatal death) |  |  |  |  |
|  | Hearing problems |  |  |  |  |
|  | Heart defects |  |  |  |  |
|  | Hormonal disorder (e.g., diabetes, thyroid) |  |  |  |  |
|  | Learning disability (e.g., neurological, organic brain dysfunction) |  |  |  |  |
|  | Mental health (e.g. depression, bi-polar, schizophrenia, anxiety) |  |  |  |  |
|  | Muscle disorder (e.g., muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida) |  |  |  |  |
|  | Seizure disorder (e.g., epilepsy, traumatic brain injury) |  |  |  |  |
|  | Substance use (e.g. alcohol, cannabis (marijuana), prescription drugs, methamphetamine, cocaine, heroin) |  |  |  |  |
|  | Vision (e.g., near-sighted, far-sighted, blind, glaucoma, cataracts) |  |  |  |  |
|  | Other known inheritable conditions (please specify) |  |  |  |  |
|  | Other medical conditions not listed above (please specify) |  |  |  |  |

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| **Birth Mother Health Status** | | | | |
| Describe the birth mother’s current health status: | | | | |
| Has the birth mother used any of the following toxic environmental substances and/or controlled substances?  Yes  No  Unknown  If yes, check all that apply and circle specific substance under each category:  Alcohol  Amphetamines  Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)  Tobacco  Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin), Suboxone/Methadone)  Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)  Cannabis (Marijuana)  Other (specify):  Has the birth mother used any substances in the presence of the child?  Yes  No  Unknown  If yes, please check all that apply and circle specific substance under each category:  Alcohol  Amphetamines  Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)  Tobacco  Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin))  Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)  Cannabis (Marijuana)  Other (specify): | | | | |
| **Child’s Birth History and Current Health** | | | | |
| Where was your child born (city, state, hospital)?  Did birth mom have prenatal care?  Yes  No  Unknown  Limited    Was the child exposed to any substances during pregnancy?  Yes  No  Unknown  If yes, please mark the substance, and specify type of substance, how often the substance was used, and during which trimester of the pregnancy:   |  |  |  | | --- | --- | --- | | Controlled substances (specify) | How often & amount used: | Trimester(s): | | Prescription drugs (specify) | How often & amount used: | Trimester(s): | | Tobacco | How often & amount used: | Trimester(s): | | Alcohol | How often & amount used: | Trimester(s): | | Other toxic substances (specify) | How often & amount used: | Trimester(s): | | | | | |
| Does mother consent to disclose specific type of disease(s) (i.e. hepatitis C, gonorrhea, HIV) the child may have been exposed to in order to provide medical care for the child?  Yes  No  If yes, please have birth mother complete and sign a [DCYF 03-475 Consent](http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/forms/14-012.pdf) and attach to the 13-041 (consent to release will only be  provided to the child’s medical providers and the current caregiver).  Was the child exposed to a blood-borne pathogen or sexually transmitted disease during pregnancy or at birth?  Yes  No  Unknown  If yes, what was the child exposed to? | | | | |
| Were there unusual circumstances noted during labor and delivery:(e.g., c-section, baby stopped breathing, umbilical cord wrapped around neck, loss of blood)  Yes  No  Unknown  If yes, what happened?  Was the child hospitalized in the PICU or NICU after birth?  Yes  No  Unknown  If yes, what was the reason? | | | | |
| Does the child have a history of any medical, dental, or mental health diagnoses?  Yes  No  If yes, what was the child diagnosed with and was there any treatment (please describe type of treatment)?  Does the child have any current medical, dental, or mental health diagnoses or any outstanding needs?  Yes  No  If yes, what is the child diagnosed with and/or the outstanding needs of the child?  Does your child have any allergies? If yes, what are they allergic to and what is the reaction? | | | | |
| **Section 2: Birth Father’s Background and Family Genetic/Medical History** | | | | |
| YEAR OF BIRTH | | RACE | | ETHNICITY |
| HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR | RELIGION |
| LEFT HANDED  RIGHT HANDED | HIGHEST GRADE ACHIEVED | | LEARNING CONCERNS | |
| HOBBIES/INTERESTS/PROFESSION | | | | |

| **BIRTH FATHER** | **MEDICAL CONDITION (PLEASE PROVIDE SPECIFIC DIAGNOSES IN THE BLANK BOX, IF APPLICABLE)** | **AGE OF ONSET, TREATMENT, MEDICATION** | **RELATIVE/FAMILY MEMBER** | **RELATIONSHIP TO BIRTH FATHER** | **AGE OF ONSET, TREATMENT, MEDICATION** |
| --- | --- | --- | --- | --- | --- |
|  | Attention Deficit Disorder (ADD)  Attention Deficit Hyperactivity Disorder (ADHD) |  |  |  |  |
|  | Allergic reaction (e.g., food, drugs, animals) |  |  |  |  |
|  | Arthritis |  |  |  |  |
|  | Birth defects |  |  |  |  |
|  | Blood-Borne Pathogen (e.g. HIV, AIDS, Hepatitis B, Hepatitis C) |  |  |  |  |
|  | Blood disorder (e.g., hemophilia, sickle cell anemia)  Yes  No |  |  |  |  |
|  | Cancer |  |  |  |  |
|  | Cardiovascular (e.g., high blood pressure, heart attack, stroke) |  |  |  |  |
|  | Developmental delays (e.g., difficulty with reading, math, writing, understanding directions, Tourette’s syndrome, dyslexia) |  |  |  |  |
|  | Fetal Alcohol Syndrome (FAS)  Fetal Alcohol Effects |  |  |  |  |
|  | Gynecological problems/history (e.g., spontaneous abortion, miscarriage, still birth, neonatal death) |  |  |  |  |
|  | Hearing problems |  |  |  |  |
|  | Heart defects |  |  |  |  |
|  | Hormonal disorder (e.g., diabetes, thyroid) |  |  |  |  |
|  | Learning disability (e.g., neurological, organic brain dysfunction) |  |  |  |  |
|  | Mental health (e.g. depression, bi-polar, schizophrenia, anxiety) |  |  |  |  |
|  | Muscle disorder (e.g., muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida) |  |  |  |  |
|  | Seizure disorder (e.g., epilepsy, traumatic brain injury) |  |  |  |  |
|  | Substance use (e.g. alcohol, cannabis (marijuana), prescription drugs, methamphetamine, cocaine, heroin) |  |  |  |  |
|  | Vision (e.g., near-sighted, far-sighted, blind, glaucoma, cataracts) |  |  |  |  |
|  | Other known inheritable conditions (please specify) |  |  |  |  |
|  | Other medical conditions not listed above (please specify) |  |  |  |  |

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| **Birth Father Health Status** |
| Describe the birth father’s current health status: |
| Has the birth father used any of the following toxic environmental substances and/or controlled substances?  Yes  No  Unknown  If yes, check all that apply and circle specific substance under each category:  Alcohol  Amphetamines  Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)  Tobacco  Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin))  Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)  Cannabis (Marijuana)  Other (specify):  Has the birth father used any substances in the presence of the child?  Yes  No  Unknown  If yes, please check all that apply and circle specific substance under each category:  Alcohol  Amphetamines  Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)  Tobacco  Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin))  Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)  Cannabis (Marijuana)  Other (specify): |