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|  | State_Seal3 STATE OF WASHINGTON  DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)  **Health / Mental Health and Education Summary** |
| Date:  To:  From: Phone: Email:  Attached, please find a comprehensive health report for the following child:    NAME OF CHILD DATE OF BIRTH  If this child is no longer living with you, please destroy this document as you would any confidential information or return it to your social worker.  **The information contained in this report is confidential, however, it should be shared with the child’s physicians, dentists and therapists to assure appropriate services are provided.**  The information included in this report is limited by the availability of health and education records. This report is supplemental to any previous health reports created. All medications listed in this report should be discussed with the child’s primary health care provider. **Please take this report with you to all health/mental health appointments.**  If I may be is assistance, or if you have any questions, please do not hesitate to call me. Also, please contact me at any time with new health and education concerns you might have for this child.  Thank you for your time.  NOTE:  **The information displayed is not a complete or current reflection of the child’s health care status.  Please consult with the child’s medical providers before using this information to guide physical or behavioral health care for a child.** All information contained in this report is confidential, and disclosed under the limitations of RCW 13.50.100.  This disclosure does not constitute a waiver of any confidentiality privilege attached to the records by operation of any state or federal law or regulation.  The recipient of these records must comply with the laws governing confidentiality and must protect the records from unauthorized disclosure.  The recipient should share this information with the child’s health care provider | |

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| State_Seal3 | DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)  **Health / Mental Health and Education Summary** | | | | | | | | | | | | | |
| **Child Information** | | | | | | | | | | | | | | |
| CHILD’S NAME | | | | | | | | | | GENDER  Male  Female | | | | DATE |
| DATE OF BIRTH | | AGE | STATE STUDENT ID | | | | | | | PERSON ID | | | | |
| **Health / Mental Health Conditions** | | | | | | | | | | | | | | |
| DATE IDENTIFIED | | END DATE | | | MEDICALLY CONFIRMED | | | | | CURRENT / HISTORICAL | | | | |
| CONDITION | | | | | | | | SOURCE | | | | | | |
| PROVIDER NAME | | | | | | | | PHONE NUMBER | | | | | | |
| COMMENTS | | | | | | | | | | | | | | |
| **Exams / Evaluations** | | | | | | | | | | | | | | |
| EXAM DATE | | PROVIDER NAME | | | | | | | | | PHONE NUMBER | | | |
| TYPE OF EXAM | | | | | | | | | | | | | | |
| EXAMS / PLANS / RECOMMENDATIONS | | | | | | | | | | | | | | |
| **Allergies** | | | | | | | | | | | | | | |
| DATE IDENTIFIED | | END DATE | | | MEDICALLY CONFIRMED | | | | | CURRENT / HISTORICAL | | | | |
| ALLERGIC TO | | | | | | | ALLERGIC REACTION | | | | | | | |
| ALLERGIC REACTION PLAN | | | | | | | | | | | | | | |
| **Medications / Equipment** | | | | | | | | | | | | | | |
| PRESCRIPTION DATE | | MEDICATION OR EQUIPMENT NAME | | | | | | | | | DOSAGE | | | |
| PROVIDER NAME | | | | | | | | | | | PHONE NUMBER | | | |
| REMARKS | | | | | | | | | | | | | | |
| **Hospitalizations** | | | | | | | | | | | | | | |
| ADMIT DATE | | DISCHARGE DATE | | | | TYPE | | | | | ER / INPATIENT | | | |
| HOSPITAL NAME | | | | | | PHONE NUMBER | | | | PROVIDER NAME | | | | |
| ADMIT / DISCHARGE INFORMATION | | | | | | | | | | | | | | |
| **Mental Health Treatment** | | | | | | | | | | | | | | |
| DATE | | TREATMENT PLAN | | | | | | | | | | | | |
| PROVIDER NAME | | | | | | | | | | | PHONE NUMBER | | | |
| COMMENTS | | | | | | | | | | | | | | |
| **Appointments** | | | | | | | | | | | | | | |
| APPOINTMENT DATE | | APPOINTMENT TIME | | | | TYPE | | | | | | | | |
| PROVIDER NAME | | | | | | | | | | | PHONE NUMBER | | | |
| **Birth Information** | | | | | | | | | | | | | | |
| WEIGHT | | HEIGHT | | | TOX SCREEN | | | | | GESTATIONAL AGE | | | APGAR | |
| EXAMS / RECOMMENDATIONS | | | | | | | | | | | | | | |
| HOSPITAL NAME | | | | | PHONE NUMBER | | | | | PROVIDER NAME | | | | |
| **Immunizations** | | | | | | | | | | | | | | |
| DATE | | IMMUNIZATION | | | | | | SOURCE | | | | | | |
| **School Information** | | | | | | | | | | | | | | |
| ENROLLED DATE | | END DATE | | | | PRIMARY SCHOOL | | | | | | | | |
| SCHOOL NAME | | | | | | DISTRICT | | | | | PHONE NUMBER | | | |
| ADDRESS CITY STATE ZIP CODE | | | | | | | | | | | | | | |
| SCHOOL YEAR / TERM | | | | CURRENT GRADE | | | | CURRENT PERFORMANCE | | | | | | |
| **Special Education** | | | | | | | | | | | | | | |
| SPECIAL EDUCATION SERVICES NEEDED OR PROVIDED  Yes  No | | | | SUPPORTING DETAIL | | | | | | | | | | |
| TYPE  IEP  504  IFSP | | | | START DATE | | | | | REVIEW DATE | | | END DATE | | |
| COMMENTS | | | | | | | | | | | | | | |
| **Referrals** | | | | | | | | | | | | | | |
| REFERRAL DATE | | REFERRAL TO: | | | | | | | | | | | | |
| COMMENTS | | | | | | | | | | | | | | |