Revised 09/13/06

MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES

CHILD HEALTH INVENTORY

Name _____ Birth Date_____ Sex _____

Parent/Guardian _____ Telephone# ( )_____

Home/Address _____ City _____ State _____ Zip_____

In case of emergency notify [if parent/guardian not available]:

Name _____ Telephone# ( )_____

Address _____ City_____ State_____ Zip _____

HISTORY OF:

1. Childhood Diseases _____

2. Operations or Serious Injuries (*Dates*) _____

3. Chronis or Recurring Illnesses _____

4. Diseases or Disorders (*Convulsive disorders, asthma, diabetes, sickle cell, HIV, hepatitis, cancer, recent post surgical patient, etc.*) Yes _____ No _____

   List _____

5. Allergies: Food (*Name*) _____ Drug (*Name*) _____

6. Physical Disabilities: (*Blindness, inability to walk, hearing, missing limbs, etc.*)
   Limits Activities: Yes _____ No _____

   List _____

7. Compulsive Habits: (*Bed-wetting, finger sucking, etc.*) Yes _____ No _____

8. Substance Abuse : Yes ____ No____; If yes, which drugs(s) _____

9. Emotional/Mental/Behavioral: Yes _____ No _____

   List _____

   Hospitalizations: (*Place/Date*) _____

10. IS THE CHILD UNDER A DOCTOR'S CARE FOR ANY REASON?
Yes ___ No ___ Doctor's Name _____ Telephone# _____
Address _____ City _____ State _____ Zip_____
Reason under doctor's care _____
Does the child wear contact lens? Yes ____ No _____
Does the child wear braces? Yes ____ No _____
Does the child wear a prosthetic device? Yes _____ No _____ If yes, what devise:
_____

11. **If Female: Pregnant** Yes _____ No _____ ; if yes, list any known complication:
_____

12. **IMMUNIZATION:** See attached form for verification.

IMPORTANT: Please notify the Department of Human Services if a child is exposed to any communicable diseases during the three week period immediately prior to entering Oakley.

13. **IS THE CHILD TAKING MEDICATION FOR ANY MEDICAL CONDITION?**
Who is the child's doctor? _____
What medication is prescribed: _____
_____
In what dosage? _____
When did the child last take the medication described above? _____
In what dosage? _____
Do you have any medication on hand? Yes _____ No _____

14. **Any Medical Restrictions on Activities?** _____
_____

15. **Medicaid #** _____ **CHIP #** _____
Insurance Company _____
Policy # _____ **Telephone#** _____

16. **Note other medical information:** _____

PARENT'S AUTHORIZATION: This health inventory is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. In the event that I cannot be reached in an Emergency, I hereby authorize the Division of Youth Services to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above.

Signature: _____ Date: _____

Signature: _____ Date: _____