MEDICAL PASSPORT

Michigan Department of Human Services

CASE NAME: **CASE NUMBER:** **DATE OF BIRTH:** **SEX:**

ADDRESS: **County** **District** **Section** **Unit** **Worker** **Program Number:**

MEDICAID TYPE: **SWSS Log**

MEDICAL HISTORY/MEDICAL NEEDS

FAMILY MEDICAL HISTORY:

MO=Biological Mother FA=Biological Father BOTH=Biological Parents
(Circle all that apply/or type code on line)

MO/FA/BOTH _____ Heart Problems
MO/FA/BOTH _____ Cancer
MO/FA/BOTH _____ Diabetes
MO/FA/BOTH _____ Asthma
MO/FA/BOTH _____ Allergies
MO/FA/BOTH _____ Sickle Cell Anemia
MO/FA/BOTH _____ Mental Illness
MO/FA/BOTH _____ Strokes
MO/FA/BOTH _____ High Blood Pressure
MO/FA/BOTH _____ Other _____

CHILD'S MEDICAL HISTORY:

Prenatal Care: ☐ Yes ☐ No ☐ Unknown
Alcohol or drugs taken during pregnancy?: ☐ Yes ☐ No ☐ Unknown
If Yes, specify: _____
Full Term Pregnancy: ☐ Yes ☐ No ☐ Unknown
Type of Delivery: ☐ Natural ☐ Cesarean ☐ Unknown
Birth Weight: _____ lbs _____ Oz.

List age when child:

_____ Sat Alone
_____ Crawled
_____ Walked
_____ Spoke First Word
_____ Spoke 2 to 3 Words Together

If child had any of the following, please indicate date of mos ent occurrence:

Date		Date		
_____	Measles	_____	Earache/Ear Infection	
_____	Mumps	_____	Anemia	
_____	Chicken Pox	_____	Meningitis	
_____	Whooping cough	_____	Paralysis	
_____	Scarlet Fever	_____	Heart Disease	
_____	Frequent Colds/Cough	_____	Thyroid Disease	
_____	Frequent Sore Throat	_____	Convulsions/Seizures	
_____	Tonsillitis	_____	Head Banging	
_____	Pneumonia	_____	Breath Holding	
_____	Sickle Cell Anemia	_____	Vision Problems	_____ Glasses
_____	HIV/AIDS	_____	Hearing Problems	_____ Hearing Aide
_____	Kidney/Bladder Infections	_____	Sexually Transmitted Disease	
_____	Speech			
_____	Other Medical Conditions, Specify:	_____		
_____	Chronic Illnesses, (Asthma, Diabetes, etc...), Specify:	_____		
_____	Other Forms of Self-Abuse, Specify:	_____		
_____	Allergies, Specify:	_____		
_____	Unusual Reaction to Medicine, Specify:	_____		

Child's Name: _____

DOB: _____

SWSS Log #: _____

NAME:

VACCINE	#	AGE	DATE	MANUFACTURER	DOSE (ml)
DTP	1				
DTP	2				
DTP	3				
DTP	4				
DTP	5				
Td	1				
Hep. B	1				
Hep. B	2				
Hep. B	3				
Polio	1				
Polio	2				
Polio	3				
Polio	4				
Hib b	1				
Hib b	2				
Hib b	3				
Hib b	4				
MMR	1				
MMR	2				
MMR	3				
Varicella	1				
Varicella	2				
Hep. A					

Non-Administered Vaccine	Date	Reason

Child's Primary Health Care Provider: Child's Name:

Name	Address		
City	State	Zip Code	Phone Number

PROVIDER	DATE OF SERVICE	SERVICES CODE & NAME	DIAGNOSIS CODE & NAME

Child's Name _____

RECORD ON-GOING MEDICATIONS

Date	Name of Medication	Dosage	Reason for Medication

I certify that I have obtained all known information for the child named above. This is in accordance with the Michigan Department of Human Services policy.

The Medical Passport contains:

A) All medical information required by policy or law to be provided to foster parents.
B) A basic medical history.
C) A record of all immunizations.
D) A record of on-going medications.
E) Other information concerning the child's physical and mental health.

Each of the child's placement providers (foster parent/kinship caregiver, etc.) have been provided a copy of the Medical Passport along with:

- All known history of abuse or neglect of the child;
- All known emotional and psychological problems of the child;
- All known behavioral problems of the child; and
- The documents that verify the above information.

PREVIOUS WORKER'S SIGNATURE: _____ Date _____

PREVIOUS WORKER'S SIGNATURE: _____ Date _____

PREVIOUS WORKER'S SIGNATURE: _____ Date _____

cc: Case File
Foster Parent
DHS Monitoring Worker