Confidential

Health and Education Passport

Instructions to Foster Parents

Please keep this Health and Education Passport while this child is in your care. Please keep the child's Medi-Cal card, health eligibility identification cards, Medical Consent form, Birth Certificate and Immunization record with this Passport.

Take this Passport to all medical, dental, and educational visits pertaining to the child. Remind doctors, dentists, and teachers, mental health care providers, vision care providers, and other health care providers to add or correct information on the form after each visit. Please give the corrected Passport to the social worker at your next meeting. When the child leaves your care, the latest update of this Passport will go with the child to aid the next care provider.

If you have any questions, please speak with the child's social worker and/or Public Health Nurse.

Thank you.

NAME OF AGENCY:	Contra Costa, Children & Family Services Employment & Human Services
STREET ADDRESS	
CITY AND ZIP CODE:	**COUNTY** Contra Costa
NAME OF SOCIAL WORKER	**CASELOAD ID** **TELEPHONE**

CHILD INFORMATION

CHILD'S NAME			BIRTH DATE	AGE	GENDER
NAME ALSO KNOWN BY	CHILD ID NUMBER		COURT NUMBER		
CASE NUMBER	MEDI-CAL RECORD NUMBER	MEDICAL INSURANCE COMPANY NAME / HMO	POLICY NUMBER		
ADDRESS			SOCIAL SECURITY NUMBER		
			PHONE		
ETHNICITY	RELIGION		ICWA ELIGIBILITY		
PRIMARY LANGUAGE	SECONDARY LANGUAGE				
NAME OF SUBSTITUTE CARE PROVIDER	RELATIONSHIP TO CHILD OR TYPE OF FACILITY				
SCHOOL NAME	SCHOOL ADDRESS		GRADE		
PHONE					

CURRENT HEALTH INFORMATION

☐ SENSITIVE HEALTH & MEDICAL INFORMATION ON FILE

☐ LIMITATION PUT ON SUBSTITUTE CARE PROVIDER'S ABILITY TO MAKE HEALTH DECISIONS

☐ INDIVIDUAL HEALTH CARE PLAN ON FILE FOR SPECIAL NEEDS CHILD

**** ALERTS ****

DESCRIPTION

ALLERGIES

DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

ONSET DATE/FIRST VISIT DIAGNOSED BY

SUMMARY OF CHILD'S CURRENT HEALTH CONDITION

DEVELOPMENTAL / FUNCTIONAL LIMITATIONS

☐ VISUAL IMPAIRMENT
☐ SPECIAL DIET REQUIRED
☐ DEVELOPMENTALLY DISABLED
☐ DEVELOPMENTALLY DELAYED
☐ HEARING IMPAIRMENT
☐ NEUROLOGICAL IMPAIRMENT
☐ NON AMBULATORY
☐ SPECIAL EDUCATION PUPIL, CERTIFIED
☐ SPEECH IMPAIRMENT
☐ MEDICAL EQUIPMENT REQUIRED
☐ MEDICAL PROCEDURES REQUIRED
☐ EMOTIONAL DISORDER, DSM, CURNT REV

☐ DEVELOPMENTALLY DELAYED – COGNITIVE
☐ DEVELOPMENTALLY DELAYED – MOTOR
☐ OTHER DESCRIPTION

CURRENT HEALTH ISSUES

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS START DATE PROJECTED END DATE END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
MEDICATION COMMENTS / INSTRUCTIONS:			

WELL CHILD EXAM

DATE	EXAM TYPE			SERVICE PROVIDER	
AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE
COMMENTS / OUTCOMES / REFERRALS					
DATE	EXAM TYPE			SERVICE PROVIDER	
AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE
COMMENTS / OUTCOMES / REFERRALS					
DATE	EXAM TYPE			SERVICE PROVIDER	
AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE
COMMENTS / OUTCOMES / REFERRALS					

IMMUNIZATIONS

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

CURRENT DEVELOPMENTAL AND MENTAL HEALTH SCREENINGS

DATE	TYPE	SCREENED BY	RESULTS
COMMENTS			

CURRENT DEVELOPMENTAL AND MENTAL HEALTH REFERRALS

REFERRAL DATE	REFERRAL TYPE	REFERRED TO	OUT OF COUNTY ☐
OUTCOME OF REFERRAL	OUTCOME DATE	CONSENT TYPE	CONSENT ON FILE DATE
COMMENTS			

CURRENT DEVELOPMENTAL AND MENTAL HEALTH DATA

PLAN TYPE	START DATE	COMMENTS

MEETS MEDICAL NECESSITY DATE

INTERVENTION CHOICE	START DATE	END DATE	COMMENTS

CURRENT HEALTH SERVICE PROVIDERS

CURRENTLY RECEIVES SERVICES FROM:

☐ CA CHILDREN'S SERVICES ☐ REGIONAL CENTER ☐ OTHER

SERVICE PROVIDER NAME | SERVICE PROVIDER TYPE | DATE LAST SEEN

CLINIC/AGENCY NAME, IF ANY | ADDRESS

PHONE

SERVICE PROVIDER NAME | SERVICE PROVIDER TYPE | DATE LAST SEEN

CLINIC/AGENCY NAME, IF ANY | ADDRESS

PHONE

PAST HEALTH INFORMATION

BIRTH HISTORY

BIRTH PLACE / HOSPITAL NAME	BIRTH LOCATION (CITY COUNTY STATE AND COUNTRY)

WEIGHT	LENGTH	HEAD CIRCUMFERENCE	APGAR	GESTATION AGE

TOXICOLOGY SCREENING | NEWBORN SCREENING RESULTS

PRENATAL / PERINATAL COMMENTS

PAST HEALTH ISSUES

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	END DATE

DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☐ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT

PAST DEVELOPMENTAL AND MENTAL HEALTH SCREENINGS

DATE	TYPE	SCREENED BY	RESULTS

COMMENTS

PAST DEVELOPMENTAL AND MENTAL HEALTH REFERRALS

REFERRAL DATE	REFERRAL TYPE	REFERRED TO	OUT OF COUNTY ☐
OUTCOME OF REFERRAL	OUTCOME DATE	CONSENT TYPE	CONSENT ON FILE DATE
COMMENTS			

PAST DEVELOPMENTAL AND MENTAL HEALTH DATA

PLAN TYPE	START DATE	END DATE	END REASON
MEETS MEDICAL NECESSITY DATE			
COMMENTS			
INTERVENTION CHOICE	START DATE	END DATE	COMMENTS

PAST HEALTH SERVICE PROVIDERS

PREVIOUSLY RECEIVED SERVICES FROM:

☐ CA CHILDREN'S SERVICES ☐ REGIONAL CENTER ☐ OTHER

SERVICE PROVIDER NAME SERVICE PROVIDER TYPE DATE LAST SEEN

CLINIC/AGENCY NAME, IF ANY ADDRESS

PHONE

FAMILY MEDICAL HISTORY

MATERNAL - SIGNIFICANT HEALTH PROBLEMS

PATERNAL - SIGNIFICANT HEALTH PROBLEMS

EDUCATION INFORMATION

PARENT(S) / GUARDIANS EDUCATIONAL RIGHTS LIMITED? ☐ YES ☒ NO

COURT APPOINTED EDUCATION REPRESENTATIVE	CAER RELATIONSHIP	PHONE NUMBER

DOES THE CHILD HAVE AN INDIVIDUALIZED EDUCATION PROGRAM (IEP/IIFSP)? ☐ YES ☒ NO MOST RECENT IEP DATE:

IS IT IN THE BEST INTEREST OF THE CHILD TO REMAIN IN THE SCHOOL OF ORIGIN? ☐ YES ☐ NO ☐ NOT APPLICABLE DECISION DATE:

LOCATION OF EDUCATIONAL RECORDS / ATTEMPTS TO ACQUIRE

ARE TRANSITIONAL INDEPENDENT LIVING SERVICES BEING PROVIDED? ☐ YES ☒ NO

HAS THE CLIENT GRADUATED FROM HIGH SCHOOL? ☐ YES ☒ NO

HAS THE CLIENT COMPLETED AT LEAST ONE SEMESTER OF COLLEGE? ☐ YES ☒ NO

HAS THE CLIENT ATTENDED POSTSECONDARY/VOCATIONAL TRAINING? ☐ YES ☒ NO

CLIENT SPECIAL EDUCATION

INSTRUCTION RECEIVED?	START DATE	END DATE
☐ YES ☒ NO		

CURRENT

SCHOOL NAME	PHONE

SCHOOL ADDRESS:

TYPE OF SCHOOL:

CONTACT NAME	START DATE	SCHOOL OF ORIGIN?
		☐ YES ☐ NO

EXPLANATION IF CHILD WAS NOT PLACED IN PROXIMITY OF PREVIOUS SCHOOL ENROLLMENT

SPECIAL EDUCATION NEEDS OF THIS CHILD

REDUCED PRICE MEAL PROGRAM?	GRADUATION TYPE	GRADUATION METHOD
☐ YES ☒ NO		

GRADE	GRADE LEVEL PERFORMANCE	TEACHER / COUNSELOR NAME	START DATE

RECEIVED TUTORING?
☐ YES ☐ NO

EDUCATIONAL NEEDS / SCHOOL PERFORMANCE / STRENGTHS / INTERESTS

PREVIOUS

SCHOOL NAME	PHONE
SCHOOL ADDRESS:	
TYPE OF SCHOOL:	

CONTACT NAME	START DATE	END DATE
REASON CHILD LEFT SCHOOL		
SPECIAL EDUCATION NEEDS OF THIS CHILD		

REDUCED PRICE MEAL PROGRAM? ☐ YES ☒ NO	GRADUATION TYPE	GRADUATION METHOD

GRADE	GRADE LEVEL PERFORMANCE	TEACHER / COUNSELOR NAME	START DATE	END DATE

RECEIVED TUTORING?
☐ YES ☒ NO

EDUCATIONAL NEEDS / SCHOOL PERFORMANCE / STRENGTHS / INTERESTS