FORM 631-A

Health Passport

MEDI-ALERT

(See instructions on reverse)

☐ ORIGINAL
☐ UPDATE *(Complete 1, 5, 8, plus new information)*

I. CHILD'S CURRENT HEALTH CARE PROVIDERS

A. NAME AND ADDRESS	B. NAME AND ADDRESS

SPECIALTY	TELEPHONE	SPECIALTY	TELEPHONE

1. CHILD'S NAME

2. DATE OF BIRTH	3. SEX	4. MA # or HEALTH INS.

5. WORKER COMPLETING FORM & ID #	6. TELEPHONE

7. LOCAL DSS / UNIT	8. DATE FORM COMPLETED

II. PLACEMENT INFORMATION

A. DATE OF PLCMT. OR RE-PLCMT.	B. TYPE	C. HEALTH REPORT (631-E)	D. COMMENTS
	☐ INITIAL ☐ REPLACEMENT	☐ REPORT ATTACHED ☐ NOT EXAMINED	

III. CHRONIC HEALTH PROBLEMS

A. PHYSICAL

- ☐ ANEMIA
- ☐ ASTHMA / WHEEZING
- ☐ BEDWETTING
- ☐ CONSTIPATION
- ☐ DELAYED DEVELOPMENT
- ☐ DIABETES *(sugar)*
- ☐ DIARRHEA
- ☐ EAR INFECTION
- ☐ ECZEMA RASHES
- ☐ EPILEPSY / SEIZURES
- ☐ HEARING
- ☐ HEART PROBLEMS
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV + / AIDS
- ☐ IRREGULAR / PAINFUL MENSES
- ☐ LEAD POISONING
- ☐ LUNG DISEASE
- ☐ SICKLE CELL
- ☐ SPEECH
- ☐ SORE THROAT
- ☐ SOILING CLOTHING
- ☐ SUBSTANCE ABUSE
- ☐ TOOTH DECAY
- ☐ URINARY TRACT / KIDNEY INFECTION
- ☐ VAGINAL DISCHARGE / INFECTION
- ☐ VISION
- ☐ OTHER *(specify)*
- ☐ NONE

B. MENTAL HEALTH

- ☐ DEPRESSION
- ☐ DISRUPTIVE / VIOLENT BEHAVIOR
- ☐ FIRE SETTING
- ☐ HEAD BANGING
- ☐ HYPERACTIVE / A.D.D.
- ☐ LYING *(aberrant)*
- ☐ SELF INJURY
- ☐ SEXUAL ACTING OUT
- ☐ STEALING
- ☐ SUICIDE ATTEMPTS
- ☐ OTHER *(specify)*
- ☐ UNKNOWN
- ☐ NONE

IV. PRESENT MEDICATION: ☐ NOT TAKING MEDICATION

NAME	PURPOSE	DOSE/FREQUENCY	DATE STARTED	DATE TO STOP	PRESCRIBING PHYSICIAN *(Name and Location)*

V. ALLERGIES / ADVERSE REACTIONS

- ☐ CHEMICALS
- ☐ FOOD
- ☐ INSECT BITES
- ☐ MEDICATIONS
- ☐ OTHER SPECIFY EACH:
- ☐ UNKNOWN
- ☐ NONE

VI. SPECIAL NEEDS

- ☐ APNEA MONITOR
- ☐ CAR SAFETY SEAT
- ☐ CRUTCHES / CANE / WALKER
- ☐ ENGLISH NOT PRIMARY LANGUAGE
- ☐ GLASSES
- ☐ HEARING AID *(left)*
- ☐ HEARING AID *(right)*
- ☐ ORTHOPEDIC APPLIANCE
- ☐ SPECIAL EDUCATION
- ☐ WHEELCHAIR
- ☐ SPECIAL DIET *(specify)*
- ☐ OTHER *(specify)*

VII. PERSONAL HYGIENE

- ☐ BATHES SELF
- ☐ DRESSES SELF
- ☐ FIXES HAIR
- ☐ NEEDS ASSISTANCE WITH ACTIVITIES OF DAILY LIVING
- ☐ UNKNOWN

VIII. FEARS / PHOBIAS

- ☐ ANIMALS
- ☐ DARKNESS
- ☐ LOUD NOISES
- ☐ OTHER *(specify)*
- ☐ UNKNOWN
- ☐ NONE

IX. ACADEMIC STATUS

SCHOOL *(Name and Address)*

TYPE OF CLASS ☐ REGULAR ☐ SPECIAL ED. ☐ OTHER *(specify)* ☐ NOT IN SCHOOL

GRADE

X. Information on the above sections was provided by: ☐ MOTHER ☐ FATHER ☐ OTHER *(specify)*

XI. COMMENTS:

FORM 631-B

Health Passport

CHILD'S HEALTH HISTORY

(See instructions on reverse)

☐ ORIGINAL
☐ UPDATE *(Complete 1, 2, 6, plus new information)*

1. CHILD'S NAME

2. DATE FORM COMPLETED

3. BIRTH DATE	4. SEX	5. LDSS	6. WORKER NAME & ID #	7. TELEPHONE

I. PRENATAL - BIRTH

CHILDREN UNDER 5 YEARS OLD

1. PRENATAL CARE PROVIDED TO MOTHER? ☐ YES ☐ NO

2. HOSPITAL CHILD BORN IN — ADDRESS — ZIP

3. GESTATION
☐ PRE TERM ☐ SINGLE BIRTH
☐ FULL TERM
☐ POST TERM ☐ MULTIPLE BIRTH

4. DELIVERY
☐ NORMAL
☐ OTHER *(specify)*
☐ UNKNOWN

5. COMPLICATIONS DURING NEWBORN PERIOD
☐ CONVULSIONS / SEIZURES ☐ JAUNDICE ☐ RESPIRATORY
☐ FEEDING PROBLEMS ☐ RED BLOOD COUNT *(high / low)* ☐ OTHER *(specify below)*
☐ INFECTIONS ☐ INTENSIVE CARE NURSERY ☐ UNKNOWN

ALL CHILDREN

6. MOTHER'S USE WHILE PREGNANT:
☐ ALCOHOL ☐ OTHER DRUGS *(specify)*
☐ TOBACCO ☐ NONE
☐ MEDICATIONS *(specify)* ☐ UNKNOWN

7. BIRTH DEFECTS

8. CHILDHOOD DISEASES
☐ CHICKEN POX
☐ OTHER *(specify)*
☐ UNKNOWN

9. ARE CHILD'S PARENTS BLOOD RELATIVES?
☐ YES
☐ NO
☐ UNKNOWN

II. HOSPITALIZATIONS

DATES	REASON / DIAGNOSIS	HOSPITAL *(Name and Address)*

III. IMMUNIZATIONS

DOSE NUMBER	VACCINE TYPE *(enter date immunized)*						
	DPT	DT (PED)	POLIO	Td	HIB	HEP-B	MMR
1st DOSE							
2nd DOSE							
3rd DOSE							
4th DOSE							
5th DOSE							

IV. SEXUAL INFORMATION

A. SEXUALLY TRANSMITTED DISEASES?	B. SEXUALLY ACTIVE?	C. BIRTH CONTROL METHOD?	D. # OF PREGNANCIES	E. LIVING CHILDREN
☐ YES *(specify)* ☐ NO	☐ YES ☐ UNK ☐ NO			

V. FAMILY HISTORY *(see list of conditions on reverse)*

SIBLINGS *(note if half sibling)*			PARENTS		
AGE	SEX	MAJOR HEALTH PROBLEMS *(or cause of death)*	RELATION	AGE	MAJOR HEALTH PROBLEMS *(or cause of death)*
			MOTHER		
			HER FATHER		
			HER MOTHER		
			FATHER		
			HIS MOTHER		
			HIS FATHER		

VI. SOURCE OF INFORMATION:

☐ MOTHER ☐ FATHER ☐ OTHER *(specify below)*

VII. ☐ ADDITIONAL CONFIDENTIAL INFORMATION AVAILABLE FROM CHILD'S WORKER.

VIII. COMMENTS *(including other significant history in aunts, uncles, and bloodcousins).*

FORM 631-C

Health Passport

DEVELOPMENT STATUS *(Ages 0 - 4 or child with disability)*

(See instructions on reverse)

1. CHILD'S NAME

2. DATE FORM COMPLETED

3. BIRTH DATE

4. WORKER COMPLETING FORM & ID #

5. WORKER TELEPHONE

6. LDSS

A. MOBILITY / SPEECH ☐ UNKNOWN

1. AGE CHILD:

SAT UP	BEGAN WALKING	BEGAN TALKING

2. SPEECH
☐ NONE ☐ PHRASES
☐ SINGLE WORDS ☐ SENTENCES

3. MOBILITY *(check all that apply)*
☐ LITTLE OR NONE ☐ WALKS
☐ SITS ☐ RUNS
☐ STANDS

4. COMMENTS

B. FEEDING ☐ UNKNOWN

1. LIQUIDS
☐ BREAST FED ☐ DRINKS FROM CUP
☐ BOTTLE FED ☐ FEEDS SELF

2. SOLID FOOD
☐ STRAINED ☐ TABLE FOOD
☐ JUNIOR

3. TYPE OF DIET
☐ REGULAR
☐ SPECIAL *(list below)*

4. BOTTLE FEEDING ONLY

a. TYPE OF FORMULA	b. AMT. PER FEEDING	c. SCHEDULE

5. FEEDING POSITION
☐ LAP ☐ TABLE
☐ HIGH CHAIR ☐ OTHER

6. TYPE EATER
☐ AVERAGE ☐ HEARTY
☐ PICKY

7. OTHER NEEDS
☐ SPECIAL NIPPLE ☐ THUMBSUCKER
☐ PACIFIER ☐ OTHER *(specify)*

8. COMMENTS *(Include food likes and dislikes of child)*

C. SLEEPING ☐ UNKNOWN

1. ENVIRONMENT
☐ BED ☐ LIGHT ON
☐ CRIB ☐ SLEEPS ALONE
☐ OTHER ☐ SLEEPS WITH SOMEONE

2. SCHEDULE

a. NAP TIME	b. BEDTIME

3. SLEEPING POSITION
☐ BACK ☐ SIDE
☐ STOMACH

4. PROBLEMS
☐ INSOMNIA ☐ SLEEPWALKING
☐ NIGHTMARES ☐ OTHER *(explain below)*

5. COMMENTS *(Include bedtime rituals e.g. telling a story, reading, singing, etc./security objects e.g. pacifier, blanket or towel, stuffed animal or toy/mood upon awakening)*

D. ELIMINATION *(Bowel Movements/Urination)* ☐ UNKNOWN

1. CURRENT STATUS
☐ CLOTH DIAPERS ☐ TRAINING PANTS
☐ DISPOSABLE DIAPERS ☐ RUBBER PANTS
☐ EITHER ☐ TOILET TRAINED

2. TOILET TRAINING ONLY

2a. WORD FOR BOWEL MOVEMENT	2b. WORD FOR URINATION	2c. METHOD
		☐ POTTIE ☐ REGULAR TOILET SEAT ☐ TOILET SEAT ATTACHMENT

3. COMMENTS

E. SPECIAL CONSIDERATIONS *(Fears, Favorite toys, etc.)*

1. COMMENTS

F. THE ABOVE INFORMATION WAS OBTAINED FROM:
☐ MOTHER
☐ FATHER
☐ OTHER *(specify)*

FORM 631-E

Health Passport

HEALTH VISIT REPORT

1. NAME OF PROVIDER *(Print or Type)*	4. CHILD'S NAME	5. DATE OF VISIT
2. FACILITY *(Name and Address)*	6. CHILD'S BIRTH DATE	
	8. WORKER NAME AND ID #	
3. TELEPHONE #	8. WORKER TELEPHONE	9. LDSS

A. TYPE OF VISIT

1. ☐ INITIAL HEALTH SCREEN
2. ☐ COMPREHENSIVE HEALTH ASSESSMENT
3. ☐ WELL CHILD / EPSDT / HEALTHY KIDS
4. ☐ SICK / EMERGENCY

5. OTHER *(specify)*

B. VISIT INFORMATION *(is completed by Health Care Provider or (2) copies of Providers report must be attached).*

1. ASSESSMENT / DIAGNOSIS:

2. IMMUNIZATIONS:

3. FOLLOW UP NEEDED? *(explain, and indicate if condition requires ongoing visits, noting frequency and expected completion dates).*

PROVIDER SIGNATURE	DATE

Health Passport

CONSENT TO HEALTH CARE AND RELEASE OF RECORDS

I, _____ , a parent or legal guardian of
(Full Name — Print clearly)

_____ , authorize the Director of the
(Child's Full Name — Print clearly)

_____ , Department of Social Services, or her/his designee:
(Jurisdiction)

1. To consent to routine, evaluative, or emergency health care for my child. The term health includes medical, mental health, vision, and dental care.

2. To give, as necessary, authorization to the approved foster care home, child placement agency or institution, where my child has been placed, to consent to routine and evaluative health care.

Further, with this consent I authorize:

1. The release of all my child's health and educational records to the Director of the local Department of Social Services or his/her designee.

2. The release, as necessary, of any/all of my child's health and educational records, by the Director of the local Department of Social Services, or his/her designee to:

   a) the child's health care providers while in foster care; and/or

   b) staff of the child's school(s), as appropriate; and/or

   c) the child's foster care provider(s), through the Health Passport.

This consent remains in effect while my child remains in the custody of the local Department of Social Services, unless I revoke the consent by notifying the Director or his/her designee in writing. I understand that I may do so at any time.

The Director or his/her designee will keep me informed of my child's health and evaluative care.

_____ _____
Date (Parent or legal guardian's signature)

☐ I could not obtain a parent or legal guardian's consent. I will petition the court for medical guardianship.

☐ The client is at least 18 years of age and is competent to sign consents when required.

☐ Parental rights have been terminated and/or medical guardianship has been awarded by the juvenile court. *(Copy of court order can be found in Section 2—LEGAL of the case record.)*

_____ _____
Worker's Signature Date

Health Passport

RECEIPT FOR HEALTH CARE PASSPORT

I have received the Health Passport for _____, a child placed in my care.

I understand that all Health Passport information is confidential*. I may share it only with health care providers and Department of Social Services staff. If I have any questions, I will contact the child's caseworker.

I will return the Health Passport to the Department of Social Services when the child leaves my care.

_____ _____

Caretaker *(print/type title if applicable)* Group Home/Institution

_____ _____

Caretaker Signature Date

VERIFICATION OF MEDI-ALERT DHR/SSA 631 A

(If a new Medi-Alert (631 A) is not completed at the time of this placement, the worker must complete this section.)

I verify that the information on the existing Medi-Alert *(DHR/SSA 631 A)* dated _____, is current and complete on the date of this placement.

_____ _____

Worker's Signature Date

RETURN OF HEALTH PASSPORT FROM CARETAKER

The above named child has been removed from the provider's care and the Health Passport returned.

_____ _____

Worker's Signature Date

* Article 88A, Section 6 of the Annotated Code of Maryland and Title .7, Subtitle .01, Chapter .02 of the Code of Maryland Regulations cover this provision.