HEALTH FORM FOR CHILDREN

Name_____ DOB_____ Sex_____
Date of last physical or doctor visit_____ Reason: _____
Name of Pediatrician_____ Telephone number_____
Child's Height_____ Child's Current Weight_____
Date of last dental check up_____
Name of Dentist_____ Telephone Number _____
Name of Optometrist _____ Telephone Number_____

Any chronic or recurring illness — Treatment/medication

_____ _____
_____ _____
_____ _____

Any hospitalizations or operations — Dates

_____ _____
_____ _____
_____ _____

Any mental health diagnosis or behavioral difficulties_____
Psychotropic Medications: _____
Current or previous therapy:_____
_____

Any Developmental concerns and/or therapist (speech, occupational, early intervention)
Please list any services and provider: _____
_____
_____

Medical history of child: (Check and give dates when possible)

Chicken pox_____ Mumps_____
Measles_____ Rubella_____
Pertussis _____ Pneumonia_____
Asthma_____ Allergies_____

**Please attach a copy of the child's current immunization record or written explanation for no immunizations*

I/We give permission to Jewish Family Service to obtain additional information from any of the listed medical providers, as needed to complete adoption related documents. This release is valid for three months from date of signature below.

_____ _____
Parent/Guardian Signatures Date: