COLORADO DEPARTMENT OF HUMAN SERVICES HEALTH PASSPORT (HPP) This HPP is to be completed for each child in care within four weeks of placement. It is to be kept with the child while in care and accompanies the child when the child is returned home, placed in a permanent placement or when the child is emancipated from care. The HPP documents should be photocopied periodically and the copies kept in the case file.

LAST	FIRST	MI	STATE ID/MEDICAID#

DATE OF BIRTH MALE/FEMALE

	Identifying Information	Date Opened	
Height:		Weight:	
Eye Color:		Scars/Identifying marks:	
Hair Color:		Other:	

### \*\*\* Child's Medical History \*\*\*

History of Chronic Health Problems (check all that apply and date diagnosed if known):

Ear Infections:	Asthma:	
Diabetes:	ADHD/ADD;	
Urinary:	Heart Problems:	
Epilepsy:	Sickle Cell:	
Other Seizure Disorders:	Positive TB Skin Test:	
Bone/Joint Problems:	Other:	

Medical Alert/Allergies:	Known Reactions/Symptoms	Emergency Response

## \*\*\*COPY OF IMMUNIZATION RECORD MUST BE ATTACHED TO THE HEALTH PASSPORT\*\*\* \*\*\* ALLERGIES & MEDICAL ALERT CONDITIONS \*\*\* (To be completed by caseworker and given to provider within 30 days of placement)

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\*\*\* Child's Medical History \*\*\* (To be completed by caseworker and given to provider within 30 days of placement)

Name of Hospital of B	irth:				Address:			
City:					State:	L		Zip:
Birth Weight:				Problem	s With Pregnan	cy/Birth:	· · · · · · · · · · · · · · · · · · ·	-1
Childhood Diseases (if k	nown list a	ge at time	of illness):	- <b>I</b>			I	
Chicken Pox:	Age:							
Measles:	Age:							··· ··· ··· ·· · · · · · · · · · · · ·
Rubella:	Age:							
Mumps:	Age:							
Other:	Age:		Specify:					
Medical/Developmental History & Problems Motor: Language: Developmental/Cognitive: Menstrual and contraceptive history: Biological family history: Please check box if anyone in child's biological family has been diagnosed or suffered from any of the following. List relation to child, use MOC (mother of child) to indicate child's biological mother and FOC (father of child) to indicate biological father of child. Use the abbreviations M = Maternal, P = Paternal (i.e. m-grandmother for maternal grandmother, p-uncle for paternal uncle, etc.)								
Diabetes:								
Developmental Disabilities:								
Epilepsy/Seizures:								···· · · · · · · · · · · · · · · · · ·
Kidney Problems:								
High Blood Pressure:	-							
Mental Health Issues:			<del>4.4</del>					
Heart Attack/Stroke (underage 60):						· · · · ·		· · · · · · · · · · · · · · · · · · ·
Positive TB Skin Test:								
Blood Disease or Anemia:							*	
Birth Defects:								
Death at young age:								
Stomach/Intestinal Problems:							<u> </u>	
Asthma:								
Hepatitis C:								
Sickle Cell:	-							
HIV/Aids:								······································
Substance Abuse:								· · · · · · · · · · · · · · · · · · ·
Other:							<u></u> ,	

## MEDICAL APPOINTMENTS/HOSPITALIZATIONS:

Doctor:				Date of appt.:
Reason for appt.:	Physical	Check-up	Illness: Hospitalization	
Injury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instructi Current medications Additional comments Referrals:	child is taking:	· · ·		
Doctor:				Date of appt.:
Reason for appt.:	Physical	Check-up	Illness: Hospitalization	·
injury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instructi Current medications Additional comments Referrals:	child is taking:			
Doctor:				Date of appt.:
Reason for appt.:	Physical	Check-up	lliness: Hospitalization	
Injury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instruct Current medications Additional comments Referrals:	ions: child is taking:		· · ·	
Doctor:		,		Date of appt.:
Reason for appt.:	Physical	Check-up	Illness: Hospitalization	
Injury:		· ·	OTHER (specify):	
Diagnosis/Outcome: Prescription/instruct Current medications Additional comment Referrals:	tions: child is taking:		· · · · · · · · · · · · · · · · · · ·	
Doctor:				Date of appt.:
Reason for appt.:	Physical	Check-up	Illness: Hospitalization	
lnjury:	· .		OTHER (specify):	
Diagnosis/Outcome Prescription/instruc Current medications Additional comment Referrals:	tions: s child is taking:			

## **DENTAL APPOINTMENTS:**

Dentist:				Date of appt.:
Reason for appt.:	Cleaning	Check-up	Cavity:	
lnjury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instruction Additional comments				
Dentist:				Date of appt.:
Reason for appt.:	Cleaning	Check-up	Cavity:	
lnjury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instruction/ Additional comments	ons: /Referrals:			
Dentist:				Date of appt.:
Reason for appt.:	Cleaning	Check-up	Cavity:	······································
injury:			OTHER (specify):	
Dentist:	Classics	Chaokum		Date of appt.:
Reason for appt.:	Cleaning	Check-up	Cavity:	·
Injury: Diagnosis/Outcome:			OTHER (specify):	
Prescription/instructi Additional comments				
Dentist:				Date of appt.:
Reason for appt.:	Cleaning	Check-up	Cavity:	
injury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instructi Additional comments				
Dentist:				Date of appt.:
Reason for appt.:	Cleaning	Check-up	Cavity:	
lnjury:			OTHER (specify):	
Diagnosis/Outcome: Prescription/instructi Additional comments	ons: /Referrals:			

# **MEDICATIONS (PAST & PRESENT):**

Medication:	Condition:	Dosage:	
Date began taking medication:		Date stopped taking medication:	
Reactions/outcome/comments:			
Prescribing Doctor:			

Medication:	Condition:	Dosage:	
Date began taking medication:		Date stopped taking medic	d
Reactions/outcome/comments:			
Prescribing Doctor:			

Medication:	Condition:	Dosage:
Date began taking medication:		Date stopped taking medication:
Reactions/outcome/comments:		
Prescribing Doctor:	· .	

Medication:	Condition:	Dosage:	
Date began taking medication:		Date stopped taking medication:	242 <b>( 3</b>
Reactions/outcome/comments:			
Prescribing Doctor:			

Medication:	Condition:	Dosage:	
Date began taking medication:		Date stopped taking medication:	
Reactions/outcome/comments:			
Prescribing Doctor:		· · · · ·	

Medication:	Condition:	Dosage:
Date began taking medication:	· · ·	Date stopped taking medication:
Reactions/outcome/comments:		
Prescribing Doctor:		

## **GENERAL PRACTIONERS:**

Name:			
Address:			
City:	St:	Zip:	
Phone:	Fax:		
Date first saw child:			
Name:			
Address:			
City:	St:	Zip:	
Phone:	Fax:		
Date first saw child:			
Name:	·	· · ·	
Address:			
City:	St:	Zip:	·
Phone:	Fax:		
Date first saw child:			
Name:	•		
Address:			
City:	St:	Zip:	
Phone:	Fax:		
Date first saw child:			
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Address:			
City:	St:	Zip:	
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Date first saw child:			
Name:			
Address:			
City:	St:	Zip:	
Phone:	Fax:		
Date first saw child:			

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### **DENTISTS:**

Name:		
Address:	-	
City:	St: Zip:	
Phone:	Fax:	
Date first saw child:		
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Name:			
Address:			
City:	St:	Zip:	
Phone:	Fax:		
Date first saw child:		· · · · · · · · · · · · · · · · · · ·	

## SPECIALISTS/OTHER MEDICAL PROFESSIONALS:

Name:	me: Specialty:			
Address:				
City:	St:	Zip:		
Phone:	1_	ax:		
Date first saw child:				

Name:		Specialty:	
Address:			
City:	St:	Zip:	
Phone:		Fax:	
Date first saw child:			

Name:	Specialty:	
Address:		
City:	St: Zip:	
Phone:	Fax:	
Date first saw child:		

## PSYCHOLOGIST AND PSYCHIATRIST/LICENSED MENTAL HEALTH PROFESSIONALS:

Address:       Image: Second se	Name:			
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# COLORADO DEPARTMENT OF HUMAN SERVICES HEALTH PASSPORT (HPP) EDUCATIONAL HISTORY (All grades from preschool on)

Grade	Year	Name of School/District	Individual Education Plan (date & type of disability)	Comments
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CWS-HP (Eff. 1-1-04)

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