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)

*** Child's Medical History ***

(To be completed by caseworker and given to provider within 30 days of placement)

Name of Hospital of Birth:		**Address:**	
City:		**State:**	**Zip:**
Birth Weight:		**Problems With Pregnancy/Birth:**	

Childhood Diseases (if known list age at time of illness):

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:	
Heart Attack/Stroke (underage 60):	
Positive TB Skin Test:	
Blood Disease or Anemia:	
Birth Defects:	
Death at young age:	
Stomach/Intestinal Problems:	
Asthma:	
Hepatitis C:	
Sickle Cell:	
HIV/Aids:	
Substance Abuse:	
Other:	

Additional medical history of biological family and/or comments:

MEDICAL APPOINTMENTS/HOSPITALIZATIONS:

Doctor:				Date of appt.:	
Reason for appt.:	Physical	Check-up	Illness:	Hospitalization	
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Current medications child is taking:
Additional comments:
Referrals:

Doctor:				Date of appt.:	
Reason for appt.:	Physical	Check-up	Illness:	Hospitalization	
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Current medications child is taking:
Additional comments:
Referrals:

Doctor:				Date of appt.:	
Reason for appt.:	Physical	Check-up	Illness:	Hospitalization	
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Current medications child is taking:
Additional comments:
Referrals:

Doctor:				Date of appt.:	
Reason for appt.:	Physical	Check-up	Illness:	Hospitalization	
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Current medications child is taking:
Additional comments:
Referrals:

Doctor:				Date of appt.:	
Reason for appt.:	Physical	Check-up	Illness:	Hospitalization	
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Current medications child is taking:
Additional comments:
Referrals:

DENTAL APPOINTMENTS:

Dentist:				Date of appt.:	
Reason for appt.:	Cleaning	Check-up	Cavity:		
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Additional comments/Referrals:

Dentist:				Date of appt.:	
Reason for appt.:	Cleaning	Check-up	Cavity:		
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Additional comments/Referrals:

Dentist:				Date of appt.:	
Reason for appt.:	Cleaning	Check-up	Cavity:		
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Additional comments/Referrals:

Dentist:				Date of appt.:	
Reason for appt.:	Cleaning	Check-up	Cavity:		
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Additional comments/Referrals:

Dentist:				Date of appt.:	
Reason for appt.:	Cleaning	Check-up	Cavity:		
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Additional comments/Referrals:

Dentist:				Date of appt.:	
Reason for appt.:	Cleaning	Check-up	Cavity:		
Injury:			OTHER (specify):		

Diagnosis/Outcome:
Prescription/instructions:
Additional comments/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 medication:	
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:			

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:				

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

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

DENTISTS:

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

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

SPECIALISTS/OTHER MEDICAL PROFESSIONALS:

Name:	Specialty:		
Address:			
City:	St:	Zip:	
Phone:	Fax:		
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:

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:				

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