|  |  |
| --- | --- |
|  | **Tennessee Department of Children’s Services****Child’s Medical Record** |

| **Last Name:**  |       | **First Name:**  |       |
| --- | --- | --- | --- |
| **DOB** |     | **SS#** |       | **Sex** |  | **Race** |  |
| **Father’s Name** |       | **Mother’s Name** |       |
| **Street Address** |       |
| **City** |       |  **State** |       | ***Zip Code*** |       |

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| --- |
| **IMMUNIZATIONS** |
| Are immunizations up to date | [ ]  Yes [ ]  No | Is copy of immunization record available |  [ ]  Yes [ ]  No |

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| **MEDICAL** |
| Name of medical provider |       | Date of last physical |       |

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| --- |
| **MENTAL HEALTH** |
| Has the child ever been treated or hospitalized for mental illness or suicide thoughts/attempt | [ ]  Yes [ ]  No |
| If yes, list dates and hospital, |       |
|  |
| Does the child have a current or past history of drug or alcohol abuse? | [ ]  Yes [ ]  No |
| If yes, please explain (what? when?) |       |
| Was treatment received? | [ ]  Yes [ ]  No |
| If yes, explain (what? when? where?)  |       |
|  |
| TB Risk Assessment Date/Results |       |
| and/ or [ ] TB (PPD) [ ]  Not at Risk [ ]  Low Risk Date/Results |       |
|  |
| **Special Needs or Disabilities** |       |
|  |
| **Current Medical Problems** |       |
|  |
| **Current Medications** |       |
| **Comments** |       |
|  |
| Physician/NP/PA name |       |
|  |  |  |  |
| Physician /NP/PA Signature |  | Date |       |