|  |  |
| --- | --- |
|  | **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*** | |  |

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

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  |