

Child Medical Update Form

Parent/Guardian Name:

Name:

SSN: xxx-xx-0123

Physician Information

1. Please list the doctors and staff that your child sees and the names of the facilities that your child **CURRENTLY** goes to.

Doctor's/Staff's full name, Address and Telephone Number	Why does your child see this doctor?	Treatment Dates (month/year)
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> (City) (State) (Zip) </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <p style="font-size: small;">Will your child see this doctor for another appointment in the future? YES or NO (circle one)</p> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Next Visit)</div>
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> (City) (State) (Zip) </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <p style="font-size: small;">Will your child see this doctor for another appointment in the future? YES or NO (circle one)</p> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Next Visit)</div>
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> (City) (State) (Zip) </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <p style="font-size: small;">Will your child see this doctor for another appointment in the future? YES or NO (circle one)</p> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Next Visit)</div>
<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Facility/Clinic/Office Name) (Telephone Number w/ac)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Doctor's/Staff's Full Name) (M.D. or D.O.) (PhD, PA-C or NP)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Street Address)</div> <div style="display: flex; justify-content: space-between; border-bottom: 1px solid black;"> (City) (State) (Zip) </div>		<div style="border-bottom: 1px solid black; margin-bottom: 5px;">(First Appointment)</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Most Recent Appointment)</div> <p style="font-size: small;">Will your child see this doctor for another appointment in the future? YES or NO (circle one)</p> <div style="border-bottom: 1px solid black; margin-bottom: 5px;">(Next Visit)</div>

Child Medical Update Form

Parent/Guardian Name:

Name:

SSN: xxx-xx-0123

Hospital Information

2. Please list any emergency room visits or hospitalizations since our last medical update.

Hospital/Urgent Care Name, Address and Telephone Number	Why did your child go to this hospital?	Treatment Dates (month/year)
_____ (Name of Hospital/Urgent Care Facility) (Telephone Number w/ac) _____ (Street Address) _____ (City) (State) (Zip)		_____ (Emergency Room) _____ (Inpatient/Hospitalized) _____ (Outpatient)
_____ (Name of Hospital/Urgent Care Facility) (Telephone Number w/ac) _____ (Street Address) _____ (City) (State) (Zip)		_____ (Emergency Room) _____ (Inpatient/Hospitalized) _____ (Outpatient)
_____ (Name of Hospital/Urgent Care Facility) (Telephone Number w/ac) _____ (Street Address) _____ (City) (State) (Zip)		_____ (Emergency Room) _____ (Inpatient/Hospitalized) _____ (Outpatient)

Medications

3. Please list all medications that your child is **CURRENTLY** taking.

Name of Medication	Prescribing Doctor

Child Medical Update Form

Parent/Guardian Name:

Name:

SSN: xxx-xx-0123

School Information

4. Please list your child's current school information.

School Name, Address and Telephone Number	Name of Current Teacher(s) or counselor	Date of Attendance
<div style="display: flex; justify-content: space-between;"> (School Name) (Telephone Number w/ac) </div>		<hr/> (First Year Attended)
(Street Address)		<hr/> (Most Recent Year Attended)
<div style="display: flex; justify-content: space-between;"> (City) (State) (Zip) </div>		Is your child in special education? (circle one) YES or NO

5. Has your child had any psychological/IQ testing or evaluations since our last medical update? (circle one) **YES** or **NO**
If yes, please complete:

Name, Address and Telephone Number	Type of Test	Date of Testing
<div style="display: flex; justify-content: space-between;"> (Doctor or Hospital) (Telephone Number w/ac) </div>		<hr/> (Month/Year)
(Street Address)		
<div style="display: flex; justify-content: space-between;"> (City) (State) (Zip) </div>		

6. Has your child had an I. E. P. since our last medical update? (circle one) **YES** or **NO**
If yes, please attach a copy.

Child Medical Update Form

Parent/Guardian Name:

Name:

SSN: xxx-xx-0123

7. What year did you last file a tax return? _____. How much were your earnings for that year? \$ _____.

8. What is your Child's Height? _____ feet _____ inches. Weight? _____ pounds.

9. Describe any significant changes in your child's condition since our last contact including any new diagnoses.

10. Are you currently working or have you attempted to work since our last medical update?
If yes, please describe the type of work, number of hours worked, and amount of your wages.

11. Please list the amount and source of any household income that you currently receive. (Including SDA, Bridge Card, Unemployment, Child Support, etc.)

12. Have you had a change in Marital Status? Yes No
I am currently (check one): Single Married Separated Divorced Widowed

13. Please list your current contact information.

Mailing address: _____
(Street Address) (Apt #)

(City) (State) (Zip)

Telephone Number: (_____) _____ Alternate Telephone Number: (_____) _____

Emergency Contact Information/
Name & Telephone Number (including area code): _____