Confidential

Health and Education Passport

Instructions to Foster Parents

Please keep this Health and Education Passport while this child is in your care. Please keep the child's Medi-Cal card, health eligibility identification cards, Medical Consent form, Birth Certificate and Immunization record with this Passport.

Take this Passport to all medical, dental, and educational visits pertaining to the child. Remind doctors, dentists, and teachers, mental health care providers, vision care providers, and other health care providers to add or correct information on the form after each visit. Please give the corrected Passport to the social worker at your next meeting. When the child leaves your care, the latest update of this Passport will go with the child to aid the next care provider.

If you have any questions, please speak with the child's social worker and/or Public Health Nurse.

Thank you.

NAME OF AGENCY:	[redacted]		
STREET ADDRESS	[redacted]		
CITY AND ZIP CODE:	[redacted]	COUNTY [redacted]	
NAME OF SOCIAL WORKER [redacted]		CASELOAD ID [redacted]	TELEPHONE [redacted]

CHILD INFORMATION

CHILD'S NAME				BIRTH DATE	AGE	GENDER
NAME ALSO KNOWN BY		CHILD ID NUMBER [redacted]		COURT NUMBER		
CASE NUMBER [redacted]	MEDI-CAL RECORD NUMBER	MEDICAL INSURANCE COMPANY NAME / HMO			POLICY NUMBER	
ADDRESS Confidential Address				SOCIAL SECURITY NUMBER PHONE		
ETHNICITY		RELIGION		ICWA ELIGIBILITY Y		
PRIMARY LANGUAGE English		SECONDARY LANGUAGE				
NAME OF SUBSTITUTE CARE PROVIDER Confidential Name		RELATIONSHIP TO CHILD OR TYPE OF FACILITY Confidential Relationship				
SCHOOL NAME [redacted] PHONE		SCHOOL ADDRESS [redacted]			GRADE [redacted]	

CHILD'S NAME | DATE OF BIRTH | CASE I.D. #

CURRENT HEALTH INFORMATION

☐ SENSITIVE HEALTH & MEDICAL INFORMATION ON FILE

☐ LIMITATION PUT ON SUBSTITUTE CARE PROVIDER'S ABILITY TO MAKE HEALTH DECISIONS

☐ INDIVIDUAL HEALTH CARE PLAN ON FILE FOR SPECIAL NEEDS CHILD

** ALERTS **

DESCRIPTION

ALLERGIES

DESCRIPTION

None Known

ONSET DATE/FIRST VISIT | DIAGNOSED BY

SUMMARY OF CHILD'S CURRENT HEALTH CONDITION

DEVELOPMENTAL / FUNCTIONAL LIMITATIONS

☒ VISUAL IMPAIRMENT
☐ SPECIAL DIET REQUIRED
☐ DEVELOPMENTALLY DISABLED
☐ DEVELOPMENTALLY DELAYED
☐ HEARING IMPAIRMENT
☐ NEUROLOGICAL IMPAIRMENT
☐ NON AMBULATORY
☐ SPECIAL EDUCATION PUPIL, CERTIFIED
☐ SPEECH IMPAIRMENT
☐ MEDICAL EQUIPMENT REQUIRED
☐ MEDICAL PROCEDURES REQUIRED
☐ EMOTIONAL DISORDER, DSM, CURNT REV

☐ OTHER DESCRIPTION

CURRENT HEALTH ISSUES

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
[redacted]	[redacted]	
DIAGNOSED BY: NAME [redacted]	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

[redacted]

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
[redacted]	[redacted]	
DIAGNOSED BY: NAME [redacted]	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

[redacted]

TREATMENT PLAN / INSTRUCTIONS

[redacted]

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
[redacted]	[redacted]		

MEDICATION COMMENTS / INSTRUCTIONS:

[redacted]

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
[redacted]	[redacted]	

DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

Psychotropic medication for psychiatric reasons. 150mg

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

CHILD'S NAME | DATE OF BIRTH | CASE I.D. #

PRESCRIBED MEDICATIONS | START DATE | PROJECTED END DATE | END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS | START DATE | PROJECTED END DATE | END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM | ONSET DATE/FIRST VISIT | NEXT SCHEDULED VISIT DATE

DIAGNOSED BY: NAME | DIAGNOSED BY: PHONE | COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM | ONSET DATE/FIRST VISIT | NEXT SCHEDULED VISIT DATE

DIAGNOSED BY: NAME | DIAGNOSED BY: PHONE | COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS | START DATE | PROJECTED END DATE | END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS | START DATE | PROJECTED END DATE | END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS | START DATE | PROJECTED END DATE | END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS | START DATE | PROJECTED END DATE | END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM | ONSET DATE/FIRST VISIT | NEXT SCHEDULED VISIT DATE

DIAGNOSED BY: NAME | DIAGNOSED BY: PHONE | COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

REFERRAL DATE

REFERRED TO

DATE SEEN

REASON

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

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MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
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HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
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HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
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HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

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DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION

TREATMENT PLAN / INSTRUCTIONS

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE

MEDICATION COMMENTS / INSTRUCTIONS:

WELL CHILD EXAM

DATE	EXAM TYPE	SERVICE PROVIDER

AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE

COMMENTS / OUTCOMES / REFERRALS

IMMUNIZATIONS

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

CHILD'S NAME | DATE OF BIRTH | CASE I.D. #

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE
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Negative

COMMENTS / RESULTS

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

Negative

COMMENTS / RESULTS

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

IMMUNIZATION TYPE	DATE GIVEN OR WAIVED	WAIVED	SOURCE OF INFORMATION / CLINIC / PHYSICIAN	NEXT DUE DATE

CURRENT DEVELOPMENTAL AND MENTAL HEALTH SCREENINGS

DATE	TYPE	SCREENED BY	RESULTS
COMMENTS			

CURRENT DEVELOPMENTAL AND MENTAL HEALTH REFERRALS

REFERRAL DATE	REFERRAL TYPE	REFERRED TO	OUT OF COUNTY ☐
OUTCOME OF REFERRAL	OUTCOME DATE	CONSENT TYPE	CONSENT ON FILE DATE
COMMENTS			

CURRENT DEVELOPMENTAL AND MENTAL HEALTH DATA

PLAN TYPE	START DATE		COMMENTS
MEETS MEDICAL NECESSITY	DATE		
INTERVENTION CHOICE	START DATE	END DATE	COMMENTS

CURRENT HEALTH SERVICE PROVIDERS

CURRENTLY RECEIVES SERVICES FROM:

☐ CA CHILDREN'S SERVICES ☐ REGIONAL CENTER ☐ OTHER

SERVICE PROVIDER NAME	SERVICE PROVIDER TYPE	DATE LAST SEEN
CLINIC/AGENCY NAME, IF ANY	ADDRESS	
PHONE		

PAST HEALTH INFORMATION

BIRTH HISTORY

BIRTH PLACE / HOSPITAL NAME	BIRTH LOCATION (CITY COUNTY STATE AND COUNTRY)			
WEIGHT	LENGTH	HEAD CIRCUMFERENCE	APGAR	GESTATION AGE
TOXICOLOGY SCREENING		NEWBORN SCREENING RESULTS		
PRENATAL / PERINATAL COMMENTS				

PAST HEALTH ISSUES

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	END DATE
DIAGNOSED BY: NAME	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? ☐ YES ☐ NO ☐ UNKNOWN
HEALTH PROBLEM DESCRIPTION		
TREATMENT		

PAST DEVELOPMENTAL AND MENTAL HEALTH SCREENINGS

DATE	TYPE	SCREENED BY	RESULTS
COMMENTS			

PAST DEVELOPMENTAL AND MENTAL HEALTH REFERRALS

REFERRAL DATE	REFERRAL TYPE	REFERRED TO	OUT OF COUNTY ☐
OUTCOME OF REFERRAL	OUTCOME DATE	CONSENT TYPE	CONSENT ON FILE DATE
COMMENTS			

PAST DEVELOPMENTAL AND MENTAL HEALTH DATA

PLAN TYPE	START DATE	END DATE	END REASON

MEETS MEDICAL NECESSITY DATE

COMMENTS

INTERVENTION CHOICE	START DATE	END DATE	COMMENTS

PAST HEALTH SERVICE PROVIDERS

PREVIOUSLY RECEIVED SERVICES FROM:

☐ CA CHILDREN'S SERVICES ☐ REGIONAL CENTER ☐ OTHER

SERVICE PROVIDER NAME SERVICE PROVIDER TYPE DATE LAST SEEN

CLINIC/AGENCY NAME, IF ANY ADDRESS

PHONE

FAMILY MEDICAL HISTORY

MATERNAL - SIGNIFICANT HEALTH PROBLEMS

PATERNAL - SIGNIFICANT HEALTH PROBLEMS

EDUCATION INFORMATION

PARENT(S) / GUARDIANS EDUCATIONAL RIGHTS LIMITED? ☐ YES ☒ NO

COURT APPOINTED EDUCATION REPRESENTATIVE	CAER RELATIONSHIP	PHONE NUMBER

DOES THE CHILD HAVE AN INDIVIDUALIZED EDUCATION PROGRAM (IEP/IIFSP)? ☐ YES ☒ NO MOST RECENT IEP DATE:

IS IT IN THE BEST INTEREST OF THE CHILD TO REMAIN IN THE SCHOOL OF ORIGIN? ☐ YES ☐ NO ☐ NOT APPLICABLE DECISION DATE:

LOCATION OF EDUCATIONAL RECORDS / ATTEMPTS TO ACQUIRE

ARE TRANSITIONAL INDEPENDENT LIVING SERVICES BEING PROVIDED? ☐ YES ☒ NO

HAS THE CLIENT GRADUATED FROM HIGH SCHOOL? ☐ YES ☒ NO

HAS THE CLIENT COMPLETED AT LEAST ONE SEMESTER OF COLLEGE? ☐ YES ☒ NO

HAS THE CLIENT ATTENDED POSTSECONDARY/VOCATIONAL TRAINING? ☐ YES ☒ NO

CLIENT SPECIAL EDUCATION

INSTRUCTION RECEIVED?	START DATE	END DATE
☒ YES ☐ NO		

CURRENT

SCHOOL NAME	PHONE

SCHOOL ADDRESS:

CONTACT NAME	START DATE	SCHOOL OF ORIGIN?
		☐ YES ☐ NO

EXPLANATION IF CHILD WAS NOT PLACED IN PROXIMITY OF PREVIOUS SCHOOL ENROLLMENT

SPECIAL EDUCATION NEEDS OF THIS CHILD

REDUCED PRICE MEAL PROGRAM?	GRADUATION TYPE	GRADUATION METHOD
☐ YES ☒ NO		

GRADE	GRADE LEVEL PERFORMANCE	TEACHER / COUNSELOR NAME	START DATE

RECEIVED TUTORING?
☐ YES ☒ NO

EDUCATIONAL NEEDS / SCHOOL PERFORMANCE / STRENGTHS / INTERESTS

EDUCATION RECORD	EXAM RESULTS	START DATE	END DATE

EDUCATION RECORD COMMENTS

SCHOOL NAME	PHONE
[redacted]	[redacted]

SCHOOL ADDRESS:

CONTACT NAME | START DATE | SCHOOL OF ORIGIN? ☐ YES ☐ NO

EXPLANATION IF CHILD WAS NOT PLACED IN PROXIMITY OF PREVIOUS SCHOOL ENROLLMENT

SPECIAL EDUCATION NEEDS OF THIS CHILD

REDUCED PRICE MEAL PROGRAM?	GRADUATION TYPE	GRADUATION METHOD
☐ YES ☒ NO		

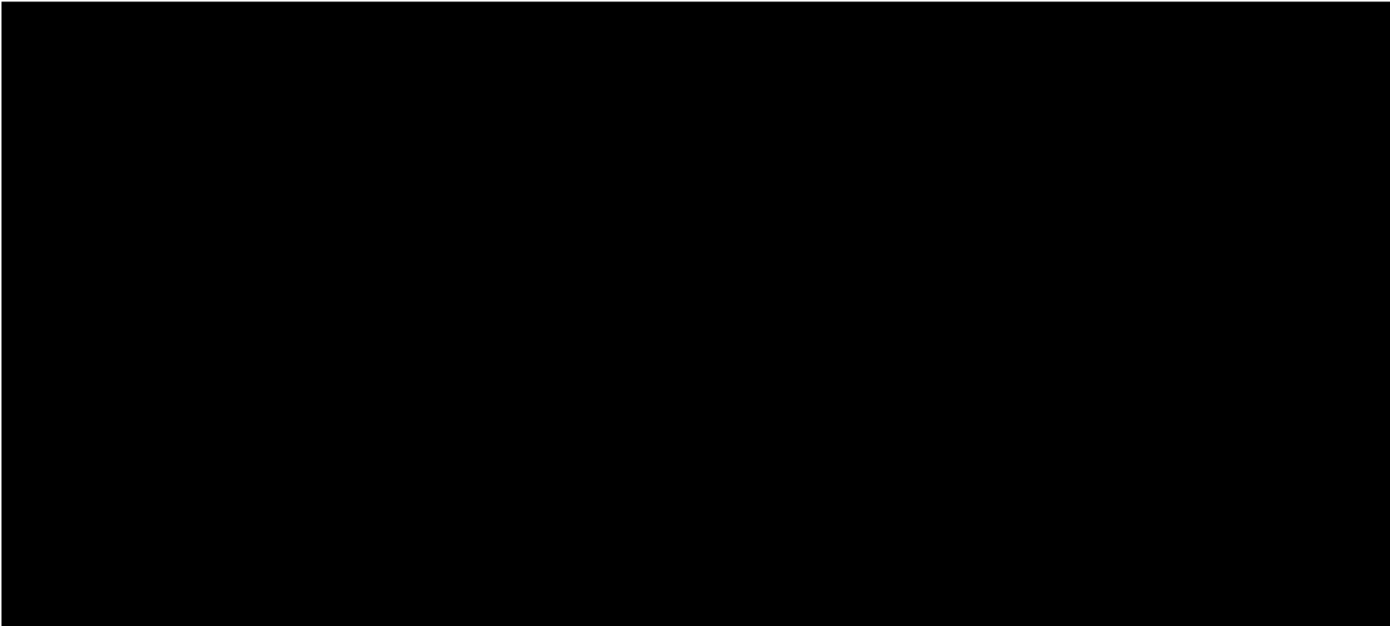
GRADE	GRADE LEVEL PERFORMANCE	TEACHER / COUNSELOR NAME	START DATE

RECEIVED TUTORING?
☐ YES ☒ NO

EDUCATIONAL NEEDS / SCHOOL PERFORMANCE / STRENGTHS / INTERESTS

EDUCATION RECORD	EXAM RESULTS	START DATE	END DATE
IEP			

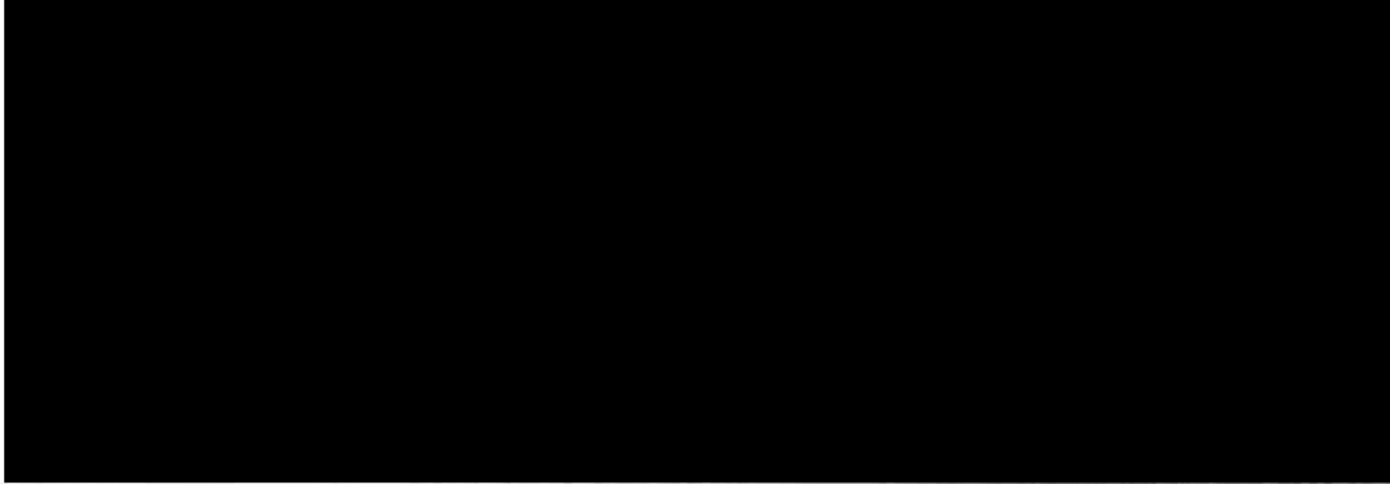
EDUCATION RECORD COMMENTS



District Graduation Requirements:
Units/Credits completed: / Units/Credits Pending:

EDUCATION RECORD	EXAM RESULTS	START DATE	END DATE
Progress Record		08/12/2015	

EDUCATION RECORD COMMENTS



PREVIOUS

SCHOOL NAME		PHONE	
SCHOOL ADDRESS:			
CONTACT NAME		START DATE	END DATE
REASON CHILD LEFT SCHOOL			
SPECIAL EDUCATION NEEDS OF THIS CHILD			

REDUCED PRICE MEAL PROGRAM?	GRADUATION TYPE	GRADUATION METHOD
☐ YES ☒ NO		

GRADE	GRADE LEVEL PERFORMANCE	TEACHER / COUNSELOR NAME	START DATE	END DATE

RECEIVED TUTORING?

☐ YES ☒ NO

EDUCATIONAL NEEDS / SCHOOL PERFORMANCE / STRENGTHS / INTERESTS

EDUCATION RECORD	EXAM RESULTS	START DATE	END DATE

EDUCATION RECORD COMMENTS

PLACE

CHILD'S PICTURE

HERE