



STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES



HEALTH SUMMARY

Case Name				Case ID #	
Child/Youth				Child ID #	
Child's Age		Child's D.O.B.		Primary Language	
Emergency Contact Name & Relationship				Phone	
				Phone	

Current Health Care Providers				
Provider Type		Name	Phone	Last Exam/Visit
Primary Care Medical Provider				
Dentist				
Mental/ Behavioral Health Professional	Psychiatrist			
	Therapist			
Medical Provider	Specialist			
	Specialist			
	Specialist			

Attach Most Current Immunization Records

Complex Medical Needs

Yes
 No
 If Yes, Level
 1
 2
 3
 4

CLASSIFICATION

Diagnoses Acute/Chronic – Past Procedures – Physical Exams

1.	_____	Baseline Physical Findings:	_____
2.	_____		_____
3.	_____	Baseline Vital Signs:	_____
4.	_____		_____
Synopsis:	_____	Baseline Neurological Status:	_____
	_____		_____

Allergies		Epi Pen: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medication/Foods to be Avoided:		Associated Adverse Reactions:		
1.				
2.				
3.				
Procedures to be Avoided:		and Why:		
1.				
2.				
3.				
Common Presenting Problems/Findings with Specific Suggested Managements				
Problem:	Suggested Diagnostic Studies:	Treatment Considerations:		
Medications (Current)				
	Dose:	Prescriber:	Date Started:	Purpose:
Special Equipment/Dietary Needs (glasses, hearing aids, nebulizer, diabetic supplies, formula type, etc.)				
Comments on Child, Family, or Other Specific Medical Issues				

Completed by:	Date:
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