MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION

CHILD/FAMILY HEALTH AND DEVELOPMENTAL ASSESSMENT

This form contains sensitive and confidential information regarding the child and his family. Information contained on this form is protected by the "Health Insurance Portability and Accountability Act." Neither the form nor its contents may be shared with any person not actively involved in the care and/or treatment of the subject child.

CHILD'S NAME	DCN	DOB	SEX

PLEASE LIST ANY PHYSICIANS YOUR CHILD HAS PREVIOUSLY SEEN

DO ANY DENTAL RECORDS EXIST FOR THIS CHILD? ☐ YES ☐ NO IF YES ▸	DENTIST NAME
HAS YOUR CHILD HAD ANY IMMUNIZATIONS? ☐ YES ☐ NO IF YES ▸	NAME OF FACILITY WHERE IMMUNIZATIONS GIVEN TO CHILD

LAST DATES OF IMMUNIZATIONS BELOW (MONTH, DAY, YEAR)

DTP SERIES	BOOSTERS	OPV SERIES	BOOSTERS

MMR (MEASLES, MUMPS, RUBELLA)	TD (TETANUS, DIPHTHERIA ADULT TYPE 14-16 YEARS)

OTHER IMMUNIZATIONS (PLEASE SPECIFY)	AGE	TREATMENT FACILITY

A. SIGNIFICANT MEDICAL PROBLEMS (PAST AND CURRENT)

PROBLEM	AGE	TREATED AT	LAST SEEN

If no significant medical problems, please write "none."

B. MEDICATION ALLERGIES AND ADVERSE REACTIONS

MEDICATION	ALLERGIC/ADVERSE REACTIONS

If no allergic or adverse reaction, please write "none."

C. CURRENT MEDICATION

MEDICATION	DATE STARTED	DOSAGE	DATE STOPPED

If no medication is being taken at present, please write "none."

D. HOSPITALIZATION OR SURGERY (STATE WHERE, WHEN, AND WHY)

E. PERINATAL HISTORY

BIRTHDATE	MATERNAL MEDICATION OR DRUGS

ANY COMPLICATIONS WITH PREGNANCY? ☐ YES ☐ NO

DID THE MOTHER HAVE ANY OF THE FOLLOWING DURING PREGNANCY? (CHECK ALL THAT APPLY)

- ☐ KIDNEY OR BLADDER INFECTION
- ☐ GERMAN MEASLES
- ☐ VENEREAL DISEASE
- ☐ X-RAYS
- ☐ HIGH BLOOD PRESSURE/TOXEMIA
- ☐ RH INCOMPATIBILITY
- ☐ DIABETES/SUGAR IN URINE
- ☐ ANY OTHER ILLNESSES (EXPLAIN BELOW)

OTHER ILLNESSES

NUMBER OF PREGNANCIES	MISCARRIAGES	WAS THIS PREGNANCY PLANNED? ☐ YES ☐ NO

F. BIRTH

NAME AND ADDRESS OF HOSPITAL WHERE CHILD WAS BORN

LABOR AND DELIVERY, ANY COMPLICATIONS

WEEKS OF GESTATION	BIRTH WEIGHT	LENGTH	NURSERY COURSE, ANY COMPLICATIONS

DID THEY BABY HAVE ANY OF THE FOLLOWING DURING THE FIRST MONTH OF LIFE? (CHECK ALL THAT APPLY)

☐ Cyanosis (Blue) ☐ Jaundice (Yellow) ☐ Convulsions ☐ Infection ☐ Deformity ☐ Bleeding

G. NUTRITIONAL HISTORY

WERE THERE ANY PROBLEMS WITH INITIAL INFANT FEEDING?

☐ YES ☐ NO

DID THIS CHILD GAIN WEIGHT PROPERLY? ☐ YES ☐ NO IF NO, ▸	EXPLAIN

REGULAR DIET? ☐ YES ☐ NO	RESTRICTIONS

PROBLEMS

H. DEVELOPMENTAL HISTORY

DID THIS CHILD START DOING THINGS ABOUT THE SAME AGE AS OTHER CHILDREN (SUCH AS WALKING, TALKING, SITTING, ETC.)

☐ YES ☐ NO

DO YOU HAVE ANY QUESTIONS/CONCERNS ABOUT HIS OR HER DEVELOPMENT?

☐ YES ☐ NO IF YES, LIST BELOW:

GIVE AGE AT WHICH YOUR CHILD DID THE FOLLOWING:

SMILED	SAT ALONE	SPOKE SINGLE WORDS	SPOKE IN SENTENCES
WALKED ALONE	FED SELF WITH SPOON	DAYTIME BLADDER CONTROL	NIGHTTIME BLADDER CONTROL
COUNTED TO FIVE			

I. PAST ILLNESSES: IF CHILD HAS HAD ANY, GIVE DATES

MEASLES	SCARLET FEVER	MUMPS	CHICKEN POX
GERMAN MEASLES	PNEUMONIA	ASTHMA	RHEUMATIC FEVER
OTHERS			

J. EDUCATIONAL HISTORY

SCHOOL NAME	GRADE	NUMBER OF DAYS MISSED LAST YEAR

ANY PROBLEMS IN SCHOOL?
☐ YES ☐ NO IF YES, EXPLAIN BELOW

TYPE OF CLASSES ATTENDED
☐ REGULAR ☐ SPECIAL

LIST ANY BEHAVIOR PROBLEMS (LIST ALL CONCERNS FOR SCHOOL AND HOME)

K. HISTORY OF PSYCHOLOGICAL SERVICES

HAS YOU CHILD RECEIVED SPECIAL COUNSELING SERVICES AT SCHOOL? ☐ YES ☐ NO	HOW LONG

WHY COUNSELING SERVICES NEEDED?

HAS YOU CHILD EVER RECEIVED ONGOING COUNSELING FROM A PSYCHOLOGIST?
☐ YES ☐ NO

IF YES, WHY

NAME OF PSYCHOLOGIST	HOW LONG

IS YOUR CHILD CURRENTLY RECEIVING ANY COUNSELING?
☐ YES ☐ NO

IF YES, BY WHOM AND FOR WHAT REASON

HAS YOUR CHILD EVER BEEN ADMITTED INTO A PSYCHIATRIC HOSPITAL OR RESIDENTIAL TREATMENT FACILITY?
☐ YES ☐ NO

IF YES, NAME AND LOCATION OF FACILITY	WHEN ADMITTED

L. FAMILY MEDICAL HISTORY

DOES ANYONE WITHIN TWO GENERATIONS HAVE ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

☐ DIABETES
☐ HIGH BLOOD PRESSURE
☐ ASTHMA
☐ HEART ATTACK
☐ TUBERCULOSIS
☐ CANCER
☐ STROKE
☐ HAYFEVER/ALLERGIES
☐ MENTAL RETARDATION
☐ LEARNING PROBLEMS
☐ EMOTIONAL PROBLEMS
☐ ANEMIA/BLOOD DISORDERS
☐ BIRTH DEFECTS
☐ EPILEPSY/SEIZURES
☐ ARTHRITIS

M. HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

THE FOLLOWING BEHAVIORS MAY PLACE AN INDIVIDUAL AT RISK FOR EXPOSURE TO HIV/AIDS AND/OR SEXUALLY TRANSMITTED DISEASES

- USE OF INJECTABLE DRUGS
- SEXUAL CONTACT WITH A PERSON WHO USES INJECTABLE DRUGS
- SEXUAL CONTACT WITH A PERSON WHO HAS HIV/AIDS
- HOMOSEXUAL ACTIVITY
- BISEXUAL ACTIVITY
- MULTIPLE SEXUAL PARTNERS
- UNPROTECTED SEXUAL ACTIVITY
- BLOOD TRANSFUSIONS

IS THERE REASON TO BELIEVE YOUR CHILD MAY HAVE BEEN EXPOSED TO HIV?
☐ YES ☐ NO

DOES CHILD (CHECK ALL THAT APPLY)

- ☐ Live in or regularly visit a house/structure with peeling or chipping paint built before 1960? This could include preschool, day care center, the home of baby-sitter or relative, etc.
- ☐ Live in or regularly visit a house/structure built before 1960 with recent, ongoing, or planned renovation or remodeling?
- ☐ Have a brother or sister, housemate, or playmate being followed or treated for lead poisoning?
- ☐ Live with an adult whose job or hobby involves exposure to lead?
- ☐ Live near an active smelter, battery recycling plant, or other industry likely to release lead?

IF THE ANSWER TO ANY QUESTION IS "YES", A BLOOD TEST SHOULD BE OBTAINED.

BLOOD TEST OBTAINED? ☐ YES ☐ NO	DATE

N. SOCIAL HISTORY

MOTHER'S NAME	BIRTHDATE	AGE	OCCUPATION
EMPLOYER NAME	TELEPHONE NUMBER		FORMAL YEARS OF EDUCATION
FATHER'S NAME	BIRTHDATE	AGE	OCCUPATION
EMPLOYER NAME	TELEPHONE NUMBER		FORMAL YEARS OF EDUCATION

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER)	WHO HAS LEGAL CUSTODY OF THE CHILD?

BROTHERS AND SISTERS (LIST ALL)

NAME	BIRTHDATE	NAME	BIRTHDATE

INFORMATION SUPPLIED BY

RELATION TO CHILD

WORKER'S SIGNATURE	DATE	PLACEMENT PROVIDER	DATE
▸		▸	
PARENT'S SIGNATURE	DATE		
▸			

CHILD/FAMILY HEALTH AND DEVELOPMENTAL ASSESSMENT (CW-103)

PURPOSE: To provide the placement provider with comprehensive health and developmental information for children in out-of-home care. A copy of the Child/Family Health and Developmental Assessment should be provided to the placement provider at the time of the initial placement and any replacements. Additionally, the assessment can be used to provide the placement provider with new or revised information.

NUMBER OF COPIES AND DISPOSITION: Three copies of the Child/Family Health and Developmental Assessment are made. One copy is retained in the family record, one copy is given to the parent and one copy is given to the placement provider.

The completed assessment may contain sensitive and confidential information regarding the child and his family. Neither the form nor its contents may be shared with any person(s) not actively involved in the care and/or treatment of the subject child.

INSTRUCTIONS FOR COMPLETION: The Child/Family Health and Developmental Assessment is completed by the child's parent. The social service worker should give the assessment form to the parent during the initial visit (within twenty-four hours of child's placement). The parent should be instructed to complete the form and return it at the time of the initial Family Support Team meeting (72 hours after the child's placement). Upon completion the assessment form is signed by the parent, social service worker and placement provider. If the parent is unavailable, the assessment form should be completed by the social worker.

Parents should be instructed to complete each section of the form as accurately and fully as possible. The social worker should explain to the parent that the information provided in Section M is confidential information and will be used only to assess whether the child should be tested for sexually transmitted diseases and/or HIV/AIDS.

INSTRUCTIONS FOR RETENTION:

This form should be kept until the case record is destroyed according to the instructions in the Child Welfare Manual.