



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
CHILDREN'S DIVISION  
HEALTH CARE INFORMATION SUMMARY

Name	DOB	DCN	Resource Home
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**A. Current health care / behavioral health providers:**

Type	Name	Clinic/address

If Other or Specialist, explain here:

**B. Current illnesses/health conditions for which child/youth is *presently* being treated - include any follow-up instructions from a recent appointment (include date of appointment, provider, & reason for appt):**

**C. Chronic/reoccurring health conditions requiring monitoring and treatment, as needed (migraines, asthma, ear infections, etc):**

**D. Describe any concerns for the child's/youth's development, or physical or behavioral health currently being monitored (ex: speech delay, possible food allergy, potential eating disorder, etc):**

**E. Current medications, including OTC:**

Medication	Dosage/frequency	Reason
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**F. Allergies – include type (ex: food, skin, pet, drug, etc), symptoms, treatments/action plans:**

**G. Significant, relevant medical/behavioral health history (illnesses, injuries, surgeries, etc):**

**H. Other helpful information to know about *this* child/youth – consider his/her emotional & physical safety, stability/anchors, social connections, etc:**

**I. Upcoming medical or behavioral health appointments:**

Date/Time	Type	Provider/Clinic & Address	Reason
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/			
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If Other or Specialist, explain here:

Indicate any services or health care appointments that need to be arranged, and by when (ex: First Steps, immunizations, eye exam, etc)

Case Manager Signature	Date Provided to Resource Provider
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