

**MISSISSIPPI DEPARTMENT OF HUMAN SERVICES
DIVISION OF YOUTH SERVICES**

CHILD HEALTH INVENTORY

Name _____ Birth Date _____ Sex _____

Parent/Guardian _____ Telephone# () _____

Home/Address _____ City _____ State _____ Zip _____

In case of emergency notify [if parent/guardian not available]:

Name _____ Telephone# () _____

Address _____ City _____ State _____ Zip _____

HISTORY OF:

1. Childhood diseases _____

2. Operations or Serious Injuries (*Dates*) _____

3. Chronic or Recurring Illness _____

4. Diseases or Disorders (*Convulsive disorder, asthma, diabetes, sickle cell disease, AIDS, hepatitis, cancer, recent post surgical patient, etc.*) Yes ___ No ___

List _____

5. Allergies: Food (*Name*) _____ Drug (*Name*) _____

6. Physical Disabilities: (*Blindness, inability to walk, hearing, missing limbs, etc.*) Limits activities: Yes ___ No ___

List _____

7. Compulsive Habits: (*Bed-wetting, finger sucking, etc.*) Yes ___ No ___

8. Substance Abuse: Yes No ___; If yes, which drug(s) _____

9. Emotional/Mental/Behavioral: Yes ___ No ___

List _____

Hospitalizations: (*Place/Date*) _____

10. IS THE CHILD UNDER A DOCTOR'S CARE FOR ANY REASON?

Yes ___ No ___ Doctor's Name _____ Telephone # _____

Address: _____ City _____ State _____ Zip _____

Reason under doctor's care _____
Does the child wear contact lens? Yes _____ No _____
Does the child wear braces? Yes _____ No _____
Does the child wear a prosthetic device? Yes _____ No _____ If yes, what device:

11. **If female: Pregnant** Yes _____ No _____ ; if yes, list any known complication:

12. **IMMUNIZATIONS:** See attached form for verification.

IMPORTANT: Please notify the Department of Human Services if child was exposed to any communicable disease during the three week period immediately prior to entering the Oakley Youth Development Center.

13. **IS THE CHILD TAKING MEDICATION FOR ANY MEDICAL CONDITION?**

Who is the child's doctor? _____

What medication is prescribed: _____

In what dosage? _____

When did the child last take the medication described above? _____

In what dosage? _____

Do you have any medication on hand? Yes _____ No _____

14. **Any Medical Restrictions on activities?** _____

15. **Medicaid #** _____ **CHIP #** _____

Insurance Company _____

Policy # _____ **Telephone #** _____

16. **Note other medical information:** _____

PARENT'S AUTHORIZATION: This health inventory is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. In the event I cannot be reached in an Emergency, I hereby authorize the Division of Youth Services to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named above.

Signature: _____

Date: _____

Signature: _____

Date: _____