



**Arkansas Department of Human Services
Division of Children and Family Services
Medi-Alert to Foster Care Provider**

I. CHILD'S INFORMATION

Name _____ SSN _____ DOB _____ Sex _____ Case # _____
 Primary Language _____ Information regarding child below provided by: Mother Father Other
 Child Receives SSI Benefits? Yes No TBD Child Receives SSA Benefits? Yes No TBD
 FSW _____ FSW Phone _____ FSW Email _____ Date _____

II. CHILD'S CURRENT CARETAKER AND HEALTH CARE PROVIDER INFORMATION

Caretaker Name _____ PCP Name _____ PCP Address _____ PCP Phone _____

III. CHILD'S PLACEMENT INFORMATION

Placement Date or Move _____ Placement Type _____ Health Report Attached? Yes No Child Not Examined

IV. CHRONIC HEALTH PROBLEMS

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Eczema/Rashes | <input type="checkbox"/> Irregular/Painful Menses | <input type="checkbox"/> Tooth Decay |
| <input type="checkbox"/> Bone/Joint Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Speech Issues | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Blood Pressure | | |

V. MENTAL/BEHAVIORAL HEALTH

- Bedwetting
- Depression
- Disruptive/Violent
- Fire Setting
- Head Banging
- Hyperactive/ADD/ADHD
- Suicide Attempts
- Other

VI. ALLERGIES

- Chemicals
- Food
- Insect Bites
- Medications
- Other

VII. SPECIAL NEEDS

- Apnea Monitor
- Contacts/Glasses (circle as applicable)
- Crutches
- Hearing Aid (circle: right/left/both)
- Orthopedic Appliance
- Special Diet
- Wheelchair
- Other

VIII. PERSONAL HYGIENE

- Bathes Self
- Dresses Self
- Fixes Hair
- Needs Assistance w/ Daily Activities

IX. FEARS/PHOBIAS

- Animals
- Darkness
- Loud Noises
- Other

X. HABITS

- Cigarettes Other
- Alcohol Use
- Illegal Drug Use
- Sexually Active

XI. EDUCATION

School _____ Grade _____ Teacher Name _____
 Class Type: Regular Special Education Has been homeschooled Not in school Refuses to go to school

XII. IMMUNIZATIONS

Was child's immunization record given to foster care provider? Yes No None Available

XIII. HOSPITALIZATIONS/SURGERIES (description and dates): _____

XIV. PRESENT MEDICATIONS

Name	Purpose	Dose/Frequency	Start Date	Stop Date	Prescribing Physician Name

XV. COMMENTS

XVI. SIGNATURES

I received a copy of the CFS-362 at placement.

I provided a copy of the CFS-362 at placement.

Foster Care Provider Name (please print)

Family Service Worker Name

Foster Care Provider Signature

Date

Family Service Worker Signature

Date