Kentucky
Department for
Community Based Services

Foster or Adopt a Child
Kentucky Cabinet for Health and Family Services

Medical Passport

Child’s Name: __________________________
Dear Care Provider *:

Assuring that the health needs of children in out-of-home care are met is a major responsibility for you and the child’s Social Service Worker. This Medical Passport was developed to help with this important task. It has been designed to be used for all children in out-of-home care, including medically fragile children, who are placed in resource homes, emergency shelters, private child care facilities, psychiatric and medical settings. It is given to the Care Provider at the time the child is placed. The Medical Passport must be maintained continuously throughout placement and accompany the child as long as he remains in out-of-home care.

The SOP and forms referred to in this Passport can be found at:

http://manuals.sp.chfs.ky.gov/Pages/index.aspx

SOP states that “resource parents are to cooperate with the Cabinet in the medical and dental care planning for the child by: (a) scheduling appointments as needed; (b) keeping immunizations current; (c) reporting to the Cabinet all encounters with medical providers and any corrective or follow-up medical or dental care the child needs; (d) maintaining the medical passport with all medical information relating to the health history and ongoing medical care of the child; (e) assisting DCBS in obtaining initial health screening within 48 hours of placement of the child; and (f) transporting children to necessary health-related (e.g. mental health, medical, dental, vision) appointment as needed.”

Why is the Medical Passport so important?

1. It ensures that all pertinent information pertaining to a child’s health care is kept in one place. This benefits the child in providing timely service when basic medical records are needed at a moment’s notice for medical care and emergencies or events such as case review, court, school enrollment, day care enrollment, and treatment planning conferences, etc.

2. Continuity of medical care is provided.

3. State Law requires that all children in out of home care receive regular medical care. State and Federal Law require the documentation of this care.

4. Care Provider Liability - Lack of documentation is equal to lack of services. In other words:

“If you don’t write it down, it didn’t happen!”

The medical passport documentation provides verification that this medical care is taking place.

5. A child’s needs and history are more easily explained to birth parents and other Care Providers upon changes in placement or changes of Social Service Workers.

How do I use this Medical Passport?

SOP states that resource parents are to maintain “the medical passport with all medical information relating to the health history and ongoing medical care of the child”. If the child will be accompanied to the appointment or exam by a Social Service Worker or transportation aid in lieu of the Care Provider, then the Social Service Worker or Care Provider will assume responsibility for the passport, share it with the medical professional, and assure that all forms are completed. Care Providers should not assign these responsibilities to the child in the Care Provider’s absence.

The medical passport includes tabs that are designed to be used with the three ring passport binder. Children who are medically fragile or who have special health care needs may require more space for documentation and record keeping. Therefore, the Care Provider may separate the tab sections into more than one volume as needed. Each child should have his/her own binder, even if siblings reside in the same foster home. Each tab section includes instructions on how to utilize the forms for that section. Other helpful hints are also included.

* In this Medical Passport, the term “Care Provider” is used to define the responsible person with whom the child lives in out-of-home care.
The forms specifically designed for use in the medical passport are the DPP-106 series. In March of 2007 the form suffixes were updated. The old and new designations in the forms top left corner are as follows:

<table>
<thead>
<tr>
<th>FORM</th>
<th>OLD NUMBER</th>
<th>NEW NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Authorization For Medical Treatment&quot;</td>
<td>DPP-106A-1</td>
<td>DPP-106A</td>
</tr>
<tr>
<td>&quot;Medical History&quot; now called</td>
<td>DPP-106A</td>
<td>DPP-106B</td>
</tr>
<tr>
<td>&quot;Initial Health Interview with Family&quot;</td>
<td>DPP-106A</td>
<td>DPP-106B</td>
</tr>
<tr>
<td>&quot;Child Medical History and Annual Physical Exam&quot;</td>
<td>DPP-106</td>
<td>DPP-106C</td>
</tr>
<tr>
<td>&quot;Medical Appointment&quot;</td>
<td>DPP-106A-2</td>
<td>DPP-106D</td>
</tr>
<tr>
<td>&quot;Dental Care&quot;</td>
<td>DPP-106A-3</td>
<td>DPP-106E</td>
</tr>
<tr>
<td>&quot;Visual Screening&quot;</td>
<td>DPP-106A-4</td>
<td>DPP-106F</td>
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<tr>
<td>&quot;Mental Health Services&quot;</td>
<td>DPP-106A-6</td>
<td>DPP-106G</td>
</tr>
<tr>
<td>&quot;Medications History&quot; now called</td>
<td>DPP-106A-5</td>
<td>DPP-106H</td>
</tr>
<tr>
<td>&quot;Methamphetamine Exposure Medical Evaluation and Follow-up&quot;</td>
<td>None</td>
<td>DPP-106I</td>
</tr>
<tr>
<td>&quot;Medication Transfer Form&quot;</td>
<td>None</td>
<td>DPP-106J</td>
</tr>
</tbody>
</table>

Forms A through H will be used at some point during the child’s stay in out-of-home care. If you run out of forms or your Passport did not have a particular form to begin with, request them from the child’s Social Service Worker and be persistent. A blank copy of Prescription and OTC Medication Administration (DPP-106H) should be kept from which to make copies as needed. A blank Methamphetamine Exposure Medical Evaluation and Follow-up form (DPP-106 I) is not included in this Passport. It is to be completed by a Social Services Worker at the time of a child’s medical evaluation. The Social Services Worker completes the form because the initial evaluation is to take place two to four hours after a child’s removal from the Methamphetamine environment.

It is very difficult to get forms filled out by medical professionals a few days or weeks after the appointment. Not having blank forms is no excuse for failing to include them in the passport. Photo copies of blank forms may be used. If photocopied forms are used, additional copies must be made for the case file once the forms are completed.

Other forms and documents used by medical professionals may be added to the passport in addition to the above forms. These may be filed under the appropriate related tab sections.

**How are copies of the forms distributed?**

Medical passport forms are either a single page or composed of carbonless paper forms with white and yellow copies. Once completed, the white copy or the original is to be kept in the passport binder. A photo copy or the yellow carbonless copy is to be given to the child’s Social Service Worker to notify him / her of the medical status of the child and is to be kept in the child’s case record. Photo copies or the yellow copies of medical, dental, and visual screening forms should be given to the child’s Social Service Worker within one week of the appointment. Photo copies or the yellow copies of medication forms should be given to the child’s Social Service Worker at the end of each month.

Passport forms in the child’s case file must be available for review by many service professionals. Medical professionals are encouraged to write legibly and press firmly. If you have a yellow copy and it cannot be read, please give the Social Service Worker a photo copy of the white original for the case file.

DO NOT allow the medical professional to keep the original completed forms. Encourage them to make photo copies and return the originals and carbons, if applicable, for passport use. You may also want to make copies of completed forms for activities such as day care, school, and camp registration/enrollment. If you do not have a resource to make photo copies, these may be made at your local DCBS office.
Effective Date: __________________________

This page should be completed with current information once a child enters out-of-home care and should be updated using the “Important Information Updates” boxes on the next tab/page as needed. Past history information should be provided in the “Medical History” section.

Child’s name: ___________________________ Date of Birth: ________________

Race: □ American Indian or Alaskan Native □ Asian or Pacific Islander □ Biracial □ Black, Non-Hispanic
□ Hispanic □ White, Non-Hispanic □ Other_______________________________

Gender: □ Female □ Male Social Security Number: ____________________________

*In the following sections related to allergies and medical diagnosis, please write “unknown” in the space provided if the information is unclear from past or current history.*

Medication Allergies: 
<table>
<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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</table>

Other Allergies (Please identify type and reactions): __________________________

Medical Diagnosis or Special Medical Needs (in brief): __________________________

Date of Child’s Original Entry Into Out-of-Home Care: __________________________ Date of Child’s Most Recent Entry: __________________________

Parental rights terminated? □ Yes □ No

Name of Mother: __________________________

Custodial parent? □ Yes □ No

Address: __________________________

Telephone Numbers: __________________________

Name of Father: __________________________

Custodial parent? □ Yes □ No

Address: __________________________

Telephone Numbers: __________________________

Other Legal Guardian: __________________________

Address: __________________________

Telephone Numbers: __________________________
### Important Information

**Child's Social Service Worker:**
- **Effective Date:**
- **Address:**
- **County:**
- **Region:**
- **Telephone Number:**
- **E-mail:**
- **FAX Number:**

**Family Services Office Supervisor:**
- **Effective Date:**
- **Address:**
- **Telephone Number:**
- **E-mail:**
- **FAX Number:**

**Pediatrician/Primary Care Physician:**
- **Effective Date:**
- **Address:**
- **Telephone Number:**
- **FAX Number:**

**Dentist:**
- **Effective Date:**
- **Address:**
- **Telephone Number:**
- **FAX Number:**

**Other Important Numbers** (relatives, medical specialists, therapists, mental health, etc.):

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<th>Name</th>
<th>Description</th>
<th>Telephone Number</th>
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**Notes:**

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Important Information Updates

Please photo copy this page as needed for additional updates.

Check one:

☐ Social Service Worker ☐ Supervisor ☐ Primary Care Physician ☐ Dentist
☐ Therapist/Counselor (Mental Health) ☐ Other ________________________

Name: ________________________________________________________________

Address: ______________________________________________________________________________

Telephone: __________________ E-mail: __________________ FAX: _______________

Effective Date: __________________

Check one:

☐ Social Service Worker ☐ Supervisor ☐ Primary Care Physician ☐ Dentist
☐ Therapist/Counselor (Mental Health) ☐ Other ________________________

Name: ________________________________________________________________

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Telephone: __________________ E-mail: __________________ FAX: _______________

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Address: ______________________________________________________________________________

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Name: ____________________________

Address: _________________________

Telephone: ______________________ E-mail: ___________________ FAX: ____________________

Effective Date: __________________
**Medical Passport Tracking History**

**Date of Original Medical Passport Issue:**

It is important that this medical passport accompany a child throughout his/her stay in out-of-home care for consistency and continuity of care. It is very difficult to recreate and/or relocate records when they are lost between placements. For this reason, Care Providers* are required to sign that the medical passport is received upon the child’s entry into their home/facility. Please record the date, type of Care Provider, and signature in columns 1, 2, 3 and 4. For type of Care Provider, see key below.

When a child leaves a foster home/other facility (i.e. changes placement), the passport is to be returned to the child’s Social Service Worker immediately. The Social Service Worker will then sign the date returned entry (columns 5 and 6), make a photo copy of this page for the child’s case record and most recent Care Provider and forward the passport to the appropriate new Care Provider, or birth parent (columns 1, 2, 3, and 4). Additional space is provided on the back of this page for continuation.

When the child leaves for respite, Care Providers should make copies of the appropriate pages of the passport which may be needed the respite period. In some cases, extended respite may require that the entire passport be transferred to the respite provider. Care Providers may use their own judgment to determine if this is necessary. Use this page to transfer the passport in such cases.

<table>
<thead>
<tr>
<th>1. Date given to Care Provider*</th>
<th>2. Care Provider* Signature</th>
<th>3. Type of Care Provider</th>
<th>4. Facility Name if applicable</th>
<th>5. Date Returned to Worker</th>
<th>6. Social Service Worker Signature</th>
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**Key for Type of Care Providers:**

- **AH** = adoptive home
- **BH** = birth home
- **CP** = care plus
- **D** = detention
- **E** = emergency shelter
- **FH** = foster home
- **H** = hospital
- **J** = juvenile justice facility
- **MF** = medically fragile foster home
- **PCC FH** = private child care foster home
- **PCC GH** = private child group home
- **PAH** = pre-adopt
- **PRTF** = psychiatric residential treatment facility
- **R** = relative/kinship care

* In this Medical Passport, the term “Care Provider” is used to define the responsible person with whom the child lives in out-of-home care.
Medical Passport Tracking History Continuation
Please make additional copies of this page as needed for continuation.

<table>
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<tr>
<th>1. Date given to Care Provider*</th>
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*In this Medical Passport, the term “Care Provider” is used to define the responsible person with whom the child lives in out-of-home care.*
**Medical History**

**Introduction:**

In order to provide for the immediate and ongoing medical needs of the child placed in out-of-home care, it is important to know as much as possible about the medical history. Prior to placement in out-of-home care, sources for this information are birth parents, relatives, prior out-of-home Care Providers, medical providers, medical records, school and day care records.

Most medical history information will be collected by the child’s Social Service Worker prior to placement or at the initial out-of-home care conference, usually held within 5 days of placement. However, Social Service Workers and Care Providers may become aware of other medical history information during the course of the child’s placement. All medical information received by the Worker or Care Provider must be shared between these two parties verbally as well as documented in the passport.

Any available medical records related to a child’s history should be copied for the Medical Passport and shared with medical professionals. Care Providers may keep these documents in this section of the medical passport.

**Using The Form “Initial Health Interview with Family” (DPP-106B)**

The child’s Social Service Worker is to help the birth parent or primary care giver of the child fill out this form. It is important that the form be filled out completely and signed by the parent so that there is no question later as to the parent’s or caregiver’s understanding of the child’s medical history, current state of health, and any medical needs and/or conditions requiring immediate response upon entry into out-of-home care.

Parents should be as specific as possible regarding types of allergies, special medical conditions, recent and past health problems and illnesses. Dates of illnesses or approximations should be recorded on this form. Surgeries should be listed specifically in the “other” section along with type and date of the procedure.

When changes or additions occur (such as allergies discovered, surgeries, and illnesses occurring in out-of-home placement like chicken pox, etc.), these are to be recorded on a new (additional) DPP-106A Medical History form and filed in this section with a photo copy or the yellow carbonless copy returned to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

The Medical History form should be discussed with the medical professional at the child’s initial exam following entry into out-of-home care. Every effort should be made to complete this form prior to this initial exam.

**Copies of Other Documents to be Included in this Section:**

- Birth Certificate
- Immunization Record
- Most recent physical prior to child’s entry into out-of-home care
- Significant medical records prior to placement

**Past Medical Professionals for this Child:**

Please list medical providers prior to the child’s placement in out-of-home care. Additional spaces are provided on the back of this page.

| Name: ____________________________ | Social Service Worker’s assessment of the child upon entry into care |
| Address: _________________________ | Allergy information |
| Type of Provider: _________________________ | Care Provider assessment of the child upon entry to their home/facility |
| Telephone Number: _________________________ | Hospital discharge summaries prior to placement |
| Dates: from: __________ to: __________ | Mental health evaluations and testing prior to placement |

**Copies of Other Documents to be Included in this Section:**

- Birth Certificate
- Immunization Record
- Most recent physical prior to child’s entry into out-of-home care
- Significant medical records prior to placement
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<td>to:</td>
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<td>Dates: from:</td>
<td>to:</td>
</tr>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Type of Provider:</td>
<td>Type of Provider:</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Dates: from:</td>
<td>to:</td>
</tr>
<tr>
<td>Notes:</td>
<td>Notes:</td>
</tr>
</tbody>
</table>

MEDICAL HISTORY
Payment for Medical Services

Medical Insurance Cards

The majority of children in out-of-home care are eligible for medical insurance, and therefore will receive an insurance card to cover their general medical needs. Please be aware that not all medical facilities and providers accept the insurance card as a form of payment. Check with the child’s Social Service Worker or your local Department for Community Based Services (DCBS) Family Support office for a listing of accepting providers in your area.

How do I know if my child is eligible for insurance coverage?

Following placement in out-of-home care, the child’s Social Service Worker will apply for the medical insurance card within two weeks. It may then take up to a month for the card to be issued. Please understand that this process may be delayed if necessary documents such as birth certificates and / or social security cards are not accessible and need to be applied or reapplied for prior to application for the insurance card.

How do I get the insurance card if my child is eligible?

An insurance card is generally issued to the Social Service Worker in the child’s name. It is mailed to the local DCBS office. There it will be copied for the file. The original card will be mailed to you.

What if I am waiting for an insurance card and my child in care needs medical care?

Often a child must first be removed from a birth parent’s insurance before a card in the child’s name can be issued. The child in your care will need appointments for medical care (i.e. at least a complete physical, dental, and vision exams) within the first two weeks of placement. You, the Care Provider need to make every effort to make and keep these appointments with the child’s current medical provider. However, you do not need to wait on the insurance card before accepting an available appointment. If you go to an appointment before you have the child’s insurance card do not pay for medical services yourself or list your name or the Social Service Worker’s name as the responsible party for payment. Contact the child’s Social Service Worker just prior to the appointment for guidance concerning payment(s).

How long do I keep my child’s medical card?

Medical insurance cards should be maintained in the medical passport for the length of stay in out of home care. The insurance cards being issued are good from year to year so do not discard them.

Medical insurance cards are sent along with the child and this Medical Passport when he/she leaves your home/facility.

Private Insurance

Some children in out-of-home care remain eligible for private insurance under their birth parent’s or guardian’s health care plan. In this situation, the child’s Social Service Worker will request a copy of the child’s insurance card from the birth parent or guardian and provide a copy of it to you. You may contact the insurance company for a list of accepting medical providers in your area.

If the private insurance plan does not cover 100% of the medical, dental, or other related expenses, the child may be eligible for the Kentucky Medical Assistance Program as a secondary payment source. The child’s Social Service Worker will apply for an insurance card for this purpose. Please refer to the information in the previous section entitled “Medical Insurance Cards.”

Payments for Special Expenses

On occasion, you may encounter some medical procedure, medications, or related expenses for children in out-of-home care that are not covered by the child’s available insurance.

Please talk with the child’s Social Service Worker to arrange for a special needs payment before arranging services or paying expenses on your own.

Justification must accompany bills for medical expenses and state if the child was ineligible or if the service was not covered by Medicaid or private insurance.

Please remember that approval must be granted in advance of any treatment.

Unplanned Medical Expenses Occurring While Out-of-State

Prior to traveling out of state with a child in your care, contact the child’s Social Service Worker to obtain approval. Obtaining prior approval for out of state travel assures that a child in your care will receive consistent and proper medical care. Ask specifically about the current procedure for payment of medical bills from out of state providers. Do this well in advance of your travel date to avoid delays.

Reimbursement for Planned Medical Care Both In and Out of State

Contact your Recruitment and Certification worker to obtain current information regarding approval for reimbursement of travel expenses in and out of state. You will need to be approved through the Department
Copies of Other Documents to be Included in this Section, if applicable:

- Medical Insurance Cards
- Private Insurance Card
- Documentation to support special needs payments
- Out of State Travel Forms

Notes:
Authorization for Medical Treatment

Introduction:

Seeking medical care and treatment for the child in out-of-home care is not as simple as it may be for a biological child because you are not the child’s biological or legal parent. **Care Providers are not authorized to sign for any medical services or treatment unless it is an emergency and the child requires immediate medical attention (see Procedures below).** Other parties such as the child’s biological parent, in some cases, and the Cabinet, in all cases have legal rights, responsibilities, and liabilities in providing for this child. To properly involve the appropriate parties, protect yourself, and provide the best possible care for your child, make sure that proper authorization procedures are followed. Please copy this section for all respite providers so that proper procedures are followed in the absence of the primary Care Provider.

Authorization Procedures per SOP:

<table>
<thead>
<tr>
<th>Type of Custody/Commitment</th>
<th>Situation</th>
<th>Approval by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Custody/Emergency Custody</td>
<td>Medical Services</td>
<td>Birth Parent or District/Family Court Judge by written approval</td>
</tr>
<tr>
<td>Temporary Custody/Emergency Custody</td>
<td>Emergency</td>
<td>Birth Parent, District/Family Court Judge, Social Service Worker (if parent and judge unavailable) Care Provider (if Worker unavailable)</td>
</tr>
<tr>
<td>Committed to Cabinet</td>
<td>Medical Services</td>
<td>Birth Parent or Social Service Worker</td>
</tr>
<tr>
<td>Committed to Cabinet</td>
<td>Emergency</td>
<td>Birth Parent or Social Service Worker or Care Provider (if Worker unavailable)</td>
</tr>
<tr>
<td>Parental Rights Terminated</td>
<td>Medical Services</td>
<td>Social Service Worker</td>
</tr>
<tr>
<td>Parental Rights Terminated</td>
<td>Emergency</td>
<td>Social Service Worker or Care Provider (if Worker unavailable)</td>
</tr>
<tr>
<td>Voluntary Commitment</td>
<td>Serious Illness/</td>
<td>Birth Parent or Social Service Worker (if parents unavailable)</td>
</tr>
<tr>
<td>Voluntary Commitment</td>
<td>Major Surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td>Birth Parent, Social Service Worker, Care Provider (if Worker and birth parent unavailable)</td>
</tr>
</tbody>
</table>

Birth parents shall be notified as soon as practicable of any emergency medical treatment, serious illness, or major surgery. When a critical situation occurs, a caregiver initiates attempts to report the situation to the SRA, or designee, immediately. The SSW or other staff assigned by the SRA or designee notifies the child’s family within one (1) working day. The Service Region Administrator and Commissioner are also notified by the worker in the case of serious injury to a child in out-of-home care.

Using The Form “Authorization For Medical Treatment” (DPP-106A)

The child’s social worker is to complete this form upon the child’s entry into out-of-home care. If the custody or commitment status changes, the worker is to fill out a new form with the appropriate date of the change and add it to this section. For your general information:

- Emergency Custody does not last longer than 72 hours.  
- Temporary Custody lasts up to 45 days and in some cases may be extended by a judge’s order.  
- Commitment to the Cabinet has no time limit.  
- Voluntary Commitment lasts for 6 months unless it has been extended upon formal review.

Please file the original or white copy and all subsequent DPP 106A-1 forms in this section of the Medical Passport. Give a copy or the yellow copy to the Child’s Worker to be filed in the child’s case record. If you do not have a resource to make photo copies, these may be made at your local DCBS office.
Introduction:
It is imperative that all children in out-of-home care be provided with proper medical care. It is REQUIRED BY STATE LAW that all children in out-of-home care receive a complete physical upon entry into out-of-home care and annual physical each year thereafter (KRS 605.110). Children under age two should have “well-baby” exams more often. Care Providers shall cooperate with the agency in the medical care planning for the child by scheduling appointments as needed per SOP.

What Does a Complete Annual Physical Include?
Your child’s annual physical is much more than a visit to the doctor’s office. It cannot be replaced or exchanged for a “sick visit” or follow up exam. Medically fragile children must also have an annual physical even though they may see a variety of medical professionals regularly.

There are a number of components that need to be completed annually to ensure that the child is continuing in good health and receiving proper care and to rule out and/or address special medical needs. An exam can be counted as an annual physical, provided that the following components are included:

- height and weight
- vital signs
- hearing and vision screening
- urinalysis
- blood screening for nutritional needs, lead poisoning and communicable diseases
- immunizations

When Should I Take My Child to the Doctor?

Upon Entering Out-of-Home Care:

DCBS SOP states that “the Social Service Worker ensures that the child receives a physical health screening within forty-eight (48) hours of an order in which a child enters custody of the Cabinet, and treatment for any injury/illness that may be a result of maltreatment within twenty-four (24) hours.” And “Within two (2) weeks of a child entering out of home care, either via a temporary order of custody or commitment, the SSW makes arrangements for a complete medical, dental and visual examinations.”

The purpose of the screening and examination is to document the medical condition of the child upon entry into care and is essential to identify any special medical needs or conditions. Please bring a completed Medical History form (DPP 106A) to this appointment.

Examinations are not required for children who exit and reenter care within 30 days, unless the child’s circumstances indicate otherwise.

The American Academy of Pediatrics recommends that the initial health screening include the following, in addition to the components of an annual physical:

- Measurement of head circumference
- Notation of bruises, scars, deformities or limitations in function
- X-rays if history of physical abuse
- Sexually transmitted disease testing when indicated clinically or by history
- Pediculosis (lice) exam
- Developmental and mental health evaluation

Please let the physician know of any special needs or past circumstances which may affect the child’s comfortability with the exam such as history of sexual abuse, fears, etc

Annual Physical Exams:

Annual physical exams are REQUIRED BY STATE LAW for all children placed in out-of-home care (KRS 605.110). The appointment should be scheduled annually and within 12 months from the appointment of the previous year.
Using the Forms “Child Medical History and Annual Physical Exam” (DPP-106C) and “Medical Appointment” (DPP-106D)

The “Child Medical History and Annual Physical Exam” DPP-106C is used at a child’s very first medical check up upon entering care and each annual exam thereafter. The “Medical Appointment” DPP-106D form is to be filled out in its entirety at all other medical appointments: school physical exams, well baby exams, sick visits, specialist visits, prenatal exams, etc. Care Providers should fill in the date of the appointment, child’s name and date of birth, the reason for the appointment, and doctor’s name, address, and phone number to ensure that these are legible. Medical professionals are to fill in the results of the exam and sign the forms. Remember to press firmly if carbonless.

Please do not substitute school physical forms for this document. Explain to the medical professional that the Cabinet tracks medical care using this form.

If you forget the forms, they may be filled out at a later date, however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the medical professional in the child’s record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Copies of Other Documents to be Included in this Section:

- Doctor’s Clinic Notes about particular visits/ exams
- Emergency Department and Hospital Discharge Summaries
- School Physical Forms

Prior to Age Two (“Well Baby”) Exams:

It is recommended by the American Academy of Pediatrics that the schedule below be followed for children under the age of two (this will assist in monitoring growth and development and assure that all required immunizations are received):

- 2 Weeks
- 2 Months*
- 4 Months*
- 6 Months*
- 11 Months
- 15 Months*
- 18 Months*

*Indicates when immunizations will coincide with these exams as required by the Center for Disease Control, 1996.

School Physical Exams are scheduled as follows:

- Before entering Kindergarten (or the Early Start/3-4 year-old programs)
- Before entering 6th grade (Middle School)
- Before participating in athletics

Immunizations will coincide with these exams as required by the Center for Disease Control, 1996.

These exams may take the place of the annual physical exam if they include the components listed on the previous page in the section entitled “What Does a Complete Annual Physical include?”

Female Children:

It is recommended by the American Council on Obstetrics and Gynecology that girls who are or have been sexually active have an annual pelvic exam and pap smear.

Older girls may prefer to see an OB/GYN instead of a pediatrician. The OB/GYN can conduct the annual physical required for all children in out-of-home care. Please explain to the doctor why the exam is needed and how to use the form.

Pregnant girls in out-of-home care are required to receive appropriate prenatal care. These appointments should be scheduled monthly as soon as the Care Provider becomes aware of her pregnancy. A prenatal exam may not take the place of the annual physical required for all children in out-of-home care. Though the two may occur together, the components of the complete physical should not be omitted (see What Does a Complete Annual Physical Include? at the beginning of the Medical Appointments section).

Other:

Your child should be taken to the doctor when ill or in need of special evaluation. Please take special care to keep scheduled appointments and/or call to reschedule in advance. Many medical professionals will bill for missed appointments when not properly cancelled or rescheduled. Please remember to reschedule any cancelled or missed appointments to ensure that your child receives his or her proper medical care.
Immunization Schedule

Care Providers to children in out-of-home care are responsible for keeping immunizations current. A copy of the child’s immunization record should be obtained and kept in the child’s Medical Passport. The following is recommended by the Center for Disease Control, 2010. If your child in care is behind on, or has not had, their immunizations, there is an approved make-up schedule. For that schedule and more detailed information about immunizations please call toll free 1-800-CDC-INFO (1-800-232-4636) or visit:

http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm

On the next page you will find a chart for children birth to 18 years of age and below is a list of descriptions for the vaccines listed on the chart.

This information is from the Immunization Action Coalition.

Vaccine Descriptions:

HepB: protects against hepatitis

DTaP: a combined vaccine that protects against diphtheria, tetanus, and pertussis (whooping cough)

Hib: protects against Haemophilus influenzae type b

PCV: protects against pneumococcal disease

Polio: protects against polio, the vaccine is also known as IPV

RV: protects against infections caused by rotavirus

Influenza: protects against influenza (flu)

MMR: protects against measles, mumps, and rubella (German measles)

Varicella: protects against varicella, also known as chickenpox

HepA: protects against hepatitis A

Exceptions to testing or immunization requirement. KRS 214.036

Nothing contained in Kentucky Revised Statutes (KRS 158.035, 214.010, 214.020, 214.032 to 214.036, and 214.990) shall be construed to require the testing for tuberculosis or the immunization of any child at a time when, in the written opinion of his attending physician, such testing or immunization would be injurious to the child’s health.

Notes:
### When Do Children and Teens Need Vaccinations?

<table>
<thead>
<tr>
<th>Age</th>
<th>HepB (Hepatitis B)</th>
<th>DTaP/Tdap (Diphtheria, tetanus, pertussis)</th>
<th>Hib (Haemophilus influenzae type b)</th>
<th>IPV (Polio)</th>
<th>PCV (Pneumococcal conjugate)</th>
<th>RV (Rotavirus)</th>
<th>MMR (Measles, mumps, rubella)</th>
<th>Varicella (Chickenpox)</th>
<th>HepA (Hepatitis A)</th>
<th>HPV (Human papillomavirus)</th>
<th>MCV4 (Meningococcal conjugate)</th>
<th>Influenza (Flu)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1–2 mos)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 months</td>
<td>✓</td>
<td>(6–18 mos)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(15–18 mos)</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 months</td>
<td>✓</td>
<td>(12–15 mos)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(2 doses given 6 mos apart at age 12–23 mos)</td>
<td></td>
</tr>
<tr>
<td>18 months</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>19–23 months</td>
<td>Catch-up</td>
<td>Catch-up</td>
<td>Catch-up</td>
<td>Catch-up</td>
<td>Catch-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4–6 years</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(One dose each fall or winter to all people ages 6 mos and older)</td>
<td></td>
</tr>
<tr>
<td>7–10 years</td>
<td>Catch-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11–12 years</td>
<td>✓</td>
<td>Tdap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13–15 years</td>
<td>Catch-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16–18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Please note:** Cases of pertussis (whooping cough) have increased in children, teens, and adults in the last few years. Tragically, some infants too young to be fully protected by vaccination have died. Ask your doctor or nurse if your children have received all the pertussis shots needed for his or her age. Also, if you haven’t had your pertussis shot, you need to get one.

**What is “Catch-up?”** If your child’s vaccinations are overdue or missing, get your child vaccinated as soon as possible. If your child has not completed a series of vaccinations on time, he or she will need only the remainder of the vaccinations in the series. There’s no need to start over.
<table>
<thead>
<tr>
<th>Disease</th>
<th>Caused by</th>
<th>Spread by</th>
<th>Signs &amp; Symptoms</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>Varicella Zoster virus</td>
<td>Air, direct contact</td>
<td>Rash, fever</td>
<td>Bacterial infections, meningitis, encephalitis, pneumonia, death.</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Corynebacterium diphtheriae bacteria</td>
<td>Air, direct contact</td>
<td>Sore throat, mild fever, membrane in throat, swollen neck</td>
<td>Heart failure, paralysis, pneumonia, death.</td>
</tr>
<tr>
<td>Hib Disease</td>
<td>Haemophilus influenza type b bacteria</td>
<td>Air, direct contact</td>
<td>May be no symptoms unless bacteria enter blood.</td>
<td>Meningitis, epiglottitis, pneumonia, arthritis, death.</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Hepatitis A virus</td>
<td>Personal contact, contaminated food or water.</td>
<td>Fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice, dark urine.</td>
<td>Liver failure, death.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hepatitis B virus</td>
<td>Contact with blood or body fluids</td>
<td>Fever, headache, malaise, vomiting, arthritis.</td>
<td>Chronic infection, cirrhosis, liver failure, liver cancer, death.</td>
</tr>
<tr>
<td>Influenza (Flu)</td>
<td>Influenza virus</td>
<td>Air, direct contact</td>
<td>Fever, muscle pain, sore throat, cough.</td>
<td>Pneumonia, Reye syndrome, myocarditis, death.</td>
</tr>
<tr>
<td>Measles</td>
<td>Measles virus</td>
<td>Air, direct contact</td>
<td>Rash, fever, cough, runny nose, pinkeye.</td>
<td>Pneumonia, ear infections, encephalitis, seizures, death.</td>
</tr>
<tr>
<td>Mumps</td>
<td>Mumps virus</td>
<td>Air, direct contact</td>
<td>Swollen salivary glands, fever, headache, malaise, muscle pain.</td>
<td>Meningitis, encephalitis, inflammation of testicles or ovaries, deafness.</td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td>Bordetella pertussis bacteria</td>
<td>Air, direct contact</td>
<td>Severe cough, runny nose, fever.</td>
<td>Pneumonia, seizures, brain disorders, ear infection, death.</td>
</tr>
<tr>
<td>Polio</td>
<td>Poliomyelitis virus</td>
<td>Through the mouth</td>
<td>May be no symptoms, sore throat, fever, nausea.</td>
<td>Paralysis, death.</td>
</tr>
<tr>
<td>Pneumococcal Disease</td>
<td>Streptococcus pneumoniae bacteria</td>
<td>Air, direct contact</td>
<td>Pneumonia (fever, chills, cough, chest pain).</td>
<td>Bacteremia (blood infection), meningitis, death.</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Rotavirus virus</td>
<td>Through the mouth</td>
<td>Diarrhea, fever, vomiting</td>
<td>Severe diarrhea, dehydration, electrolyte imbalance, kidney and liver disease, death.</td>
</tr>
<tr>
<td>Rubella (German measles)</td>
<td>Rubella virus</td>
<td>Air, direct contact</td>
<td>Rash, fever, lymphadenopathy, malaise.</td>
<td>Encephalitis, arthritis/arthritis, hemorrhage, orchitis.</td>
</tr>
<tr>
<td>Tetanus (lockjaw)</td>
<td>Clostridium tetani bacteria</td>
<td>Exposure through cuts in skin</td>
<td>Stiffness in neck, difficulty swallowing, rigid abdominal muscles, muscle spasms, fever, sweating, elevated blood pressure.</td>
<td>Broken bones, breathing difficulty, death.</td>
</tr>
</tbody>
</table>
Introduction:
Dental care for the child in out-of-home care is also very important. It is something that may have been overlooked by many birth families or previous placements, especially for children in constant transition. It is required by state law that all children in out-of-home care receive a complete dental exam upon entry into out-of-home care and annual exam each year thereafter (KRS 605.110). Care Providers shall cooperate with the agency in the dental care planning for the child by scheduling appointments as needed per SOP.

When Should I Take My Child to the Dentist?

Upon Entering Out-of-Home Care:
Arrangements are to be made for a complete dental exam for all children entering out-of-home care within the first two weeks of placement. This will document the child’s dental condition upon entry into care and identify any special dental needs. As with medical appointments, it may be difficult to get the exam scheduled within a short period of time. Again, try to explain the situation and work with your dentist, document your efforts and notify the Social Service Worker.

Please let the dentist know of any special needs or past circumstances which may affect the child’s comfort with the exam, such as history of sexual abuse, fears, etc.

Annual Exams and Cleaning:

These exams are REQUIRED BY STATE LAW for all children placed in out-of-home care (KRS 605.110). The appointment should be scheduled annually and within 12 months from the appointment of the previous year.

The annual exam usually consists of an x-ray, cleaning, and oral exam. The American Dental Association recommends that young children wait until age three for this annual exam unless there is visible decay or other problems. The child’s pediatrician or dentist can assist with other suggestions for young children.

Follow-up / Other:
Annual exams may often indicate the need for restorative work and require follow-up exams. Please take special care to keep these and all other dental appointments, cancelling and rescheduling as needed. Tooth decay does not improve with time!

The American Dental Association recommends routine exams and cleaning every six months, however the Kentucky Children’s Health Insurance (medical card) will only pay for one annual exam. Should your child’s special dental condition require more frequent exams, talk with the dentist about making a request for pre-approval to the Kentucky Medical Assistance Program. If this is denied, talk with the child’s Social Service Worker about working out an alternative billing with the dentist and special needs payment (KAR 1.350).

Any time you can see decay, your child complains of tooth pain, or teeth are injured, the child should be taken to the dentist.
Referral:

Some children may require orthodontic or other special dental care (oral surgery, etc.) as recommended by the dentist. Children should have a complete dental evaluation before beginning specialty work. It is important to follow the course of treatment recommended by any specialist regarding frequency of exams, personal care, etc.

The Orthodontist and Other Oral Specialists

Orthodontic work must be pre-approved by medicaid if the child is medicaid eligible. Usually the child is taken to an initial orthodontic evaluation appointment. The orthodontist then makes a report to the Kentucky Medical Assistance Program explaining the need and related costs. The approval process may take a number of weeks or months.

Once the report is submitted to the Kentucky Medical Assistance Program, do not switch orthodontists because the process must start all over. Do not switch orthodontists in the middle of a treatment course for the same reason. Services may not be reimbursed by medicaid in this situation.

If the child is not medicaid eligible, if private insurance does not exist or will not pay, or if medicaid denies approval for these services deemed necessary by the dentist / orthodontist, the child’s Social Service Worker may arrange for a special needs payment through the Department. Please remember that this approval must be granted in advance of any treatment.

Using the Form “Dental Care” (DPP-106E)

This form is to be filled out in its entirety at each dental/orthodontic appointment. Care Providers should fill in the date of the appointment, child’s name and date of birth, and the dentist’s or orthodontist’s name, address, and phone number to ensure that these are legible. The dentist or orthodontist is asked to fill in all information related to the exam as indicated and sign the form. Remember to press firmly.

The “general appearance” section should state the reason for the particular appointment (i.e. annual cleaning, restoration needed, adjustment needed, appliance installed). It should also state the appearance / oral hygiene rating (i.e. good, fair, poor). The tooth status chart (middle section) should always be completed, even if there is no change from the last appointment. The follow-up appointment section should explain the need for the appointment (evaluation, restorative, annual, cleaning, etc.) and the date. If no follow-up is needed, enter the date of next annual exam on the line for the “next appointment.”

If you forget the forms, they may be filled out at a later date, however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the dentist / orthodontist in the child’s record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Notes:
Introduction:

Eye care for the child in out of home care is another important factor that may often be overlooked by many families. It is required by state law that all children in out-of-home care receive a complete visual exam upon entry into out-of-home care and annual exam each year thereafter (KRS 605.110). This may be done as part of the initial and annual physical exams. However, should the child in your care have vision needs, the annual exam should be completed by an optometrist or ophthalmologist. Some resource parents have learned from experience that children younger than school age should have exams by a pediatric ophthalmologists for the most accurate results. A vision examination by an optometrist or ophthalmologist is required by the Department of Education for all children entering school (KRS 156.160). Care Providers shall cooperate with the agency in the medical care planning for the child by scheduling appointments as needed as per SOP.

When Should I Take My Child to the Eye Doctor?

Upon Entering Out-of-Home Care:

Arrangements are to be made for a complete vision exam for all children entering out-of-home care within the first two weeks of placement. If there is no known problem, the vision screening may be done at the initial physical. However, if the child has vision problems (i.e. is already wearing glasses), these arrangements should be made with an ophthalmologist to check prescription, etc.

Annual Exams:

These exams are REQUIRED BY STATE LAW for all children placed in out-of-home care (KRS 605.110). The appointment should be scheduled annually and within 12 months from the appointment of the previous year. If there is no known problem, the annual exam / screening may be done by the child’s primary doctor as part of the annual physical. If a problem is discovered at the physical exam, the child should be taken to an ophthalmologist for further evaluation.

Follow-up / Other:

Please take special care to keep follow-up and all other appointments, cancelling and rescheduling as needed. Vision problems can lead to developmental delays, poor school performance, and behavior problems if left untreated.

Any time a teacher recommends an eye exam, the child complains of vision problems, or eyes are injured, the child should be seen by an ophthalmologist.

Using the Form “Visual Screening” (DPP-106F)

This form is to be filled out in its entirety at each eye exam. It may be filled out by the child’s primary care doctor at the initial out-of-home care exam and subsequent annual exams if the child has no need to see an eye doctor for identified vision problems. Care Providers should fill in the date of the appointment, child’s name and date of birth, and the medical professional’s name, address, and phone number to ensure that these are legible. Medical professionals are asked to fill in all information pertaining to the exam and sign the form. Remember to press firmly.

The “observation and results” section should state the reason for the particular appointment (i.e. annual exam, prescription adjustment, etc.). It should also state the diagnosis and vision rating in each eye.

The follow-up appointment section should explain the need for the appointment and the date. If no follow-up is needed, the date of the next appointment should be the next annual exam.

If you forget forms, they may be filled out at a later date, may however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the doctor in the child’s record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.
Glasses/Eye Wear

Lenses and some frames are Medicaid reimbursable. Your eye wear retailer will be able to assist you in selecting reimbursable frames. Should the child need frames that are not reimbursable or covered by private insurance, arrangements can be made with the child’s Social Service Worker for a special needs payment as per SOP.

Changes in prescription are covered by Medicaid as often as needed. Frame replacement is only covered once per year. Should your child need additional frames due to growth or frequent breakage, you will need to negotiate special needs payment through your community based services office for billing from the eye wear retailer or to be reimbursed as per SOP.

Notes:
Introduction:

Medications and their management are just as essential if not more essential than taking your child to the doctor, dentist, therapist, or specialist. Medication provides for continuation of the treatment phase beyond the medical professional’s office.

Care Providers are required to administer medications as prescribed and document the use of these medications for a child in out-of-home care. Care Providers should take special care to follow the use and proper regimen for each medication in order to carry out the medical professional’s intent and plan for treatment.

When Do I Give My Child Medication?

Prescription Medication:

Prescription medications are to be administered to a child according to the doctor’s instructions on the medication bottle, box, etc. It is unlawful to change or skip dosage, change frequency, or medication without a doctor’s order. Therefore, medication changes should be given to the Care Provider, by the doctor, in writing and changed on the prescription bottle. If a doctor does not provide the change in writing or if the change is made by telephone, request a written order immediately for your record and protection.

Care Providers can take a copy of a doctor’s order on a prescription pad to the pharmacist and request that a new label be made. This will serve to protect the child and Care Provider. Many school and childcare centers will not administer medication other than the way it is indicated on the label. It is also unlawful to give prescription medication to any other person than who is named on the prescription label.

SOP states that “resource foster parents are to give a child’s prescribed medications only with a physician’s prescription or authorization, and are to dispense in the exact amount of any medication prescribed for a child by a physician or dentist and may not stop medication without a physician’s orders.”

It is expected that DCBS staff not routinely authorize certain psychotropic drugs without prior consent from birth parents. For this reason, the Care Provider should make every effort to inform the child’s parent(s) and the child’s Social Service Worker of the plan to use this type medication even before it is prescribed. If this is not possible, SOP states resource parents are to inform the agency (child’s Social service worker) within one (1) working day of any psychotropic medication prescribed for a child.

It is preferred that psychotropic drugs be prescribed by a psychiatrist, rather than a pediatrician, for management of mood, emotional or behavioral disorder.

Some prescription medications may not be covered by the child’s Kentucky Children’s Health Insurance Program (KCHIP) Card or other health insurance. Care Providers should ask the doctor for an alternative medication that is covered or seek approval from the child’s Social Service Worker for payment of the medication as a special expense.

Over-The-Counter Medications:

Children in out-of-home care are at risk for the use of over-the-counter (OTC) medications because Care Providers and Social Service Workers often know little about the child’s medical history. For this reason, Care Providers should check with the child’s doctor before administering any OTC medications and administer them according to the package or doctors instructions.

If the doctor suggests that the medication should be given differently than instructed on the package, ask that these instructions be written on a prescription pad or other written order. Also ask the child’s doctor for a standing order for any specific OTC medications the child may need. For the child’s protection and your own, keep a copy of these within the passport folder.
OTC medications are not harmless just because they are sold without prescription. They may cause side effects or interfere with prescription medications that the child is also taking.

Troubleshooting/Prevention of Medication Errors:

1. Before leaving the doctor’s office make sure:
   a. you can read the prescription order form,
   b. you understand the dosage and
   c. you know how to administer the medication.

2. When picking up a new prescription from the pharmacy, make sure the label matches the prescription order given by the medical provider. If there is a discrepancy, contact the doctor before dispensing.

3. Keep each child’s medication separate and also separate from the medications of your own family members.

4. Observe the Six Rights of Medication Administration.
   To safely manage and administer a child’s medications one must fully understand the “six rights of medication administration”. These six rights are:
   1. Right Child 4. Right Route
   2. Right Medication 5. Right Time
   3. Right Dosage 6. Right Documentation

5. Make sure you administer the medication at the right time of day. Check with the doctor to see for example if “4 times daily” means every six hours or 4 times during the time of day the child is awake. Ask the doctor if there can be any flexibility in the schedule and get this in writing if so. Know the following abbreviations:
   - q.i.d = four times daily
   - t.i.d. = three times daily
   - b.i.d. = twice daily
   - q.d. = once a day
   - p.r.n. = as needed

6. Do not measure liquid medication (prescription or OTC) using a standard kitchen utensil or measure. Use a medication spoon or oral syringe.

7. Request that your pharmacist cut tablets for you when the dosage required is only a partial tablet.

8. Crush tablets and mix them with food only when approved by the medical Care Provider. Sometimes this will cause medication to become ineffective.

9. Store medications as directed (i.e. away from light, refrigerate, etc.) and out of the reach / access of children.

10. After the individual has taken the medication it is very important that you make sure he/she has swallowed the medication. This practice will ensure they are not hoarding or ‘checking’ medications. This is especially important for someone who has a history of choking or aspiration. Offering a snack, something additional to drink, or spending extra time with this child will allow for increased monitoring to ensure that the medication has been safely swallowed.

Using the Form “Prescription and OTC Medication Administration” (DPP-106H)

SOP requires that all medication (prescription and over-the-counter) administered to a child in out-of-home care be documented. From a legal standpoint, if it isn’t written down, it didn’t happen. This is an area in which Care Providers are extremely liable. Document to protect your child and yourself.

This form is to be filled out by the Care Provider or whoever is giving the medication. Each time a child is administered a dose of medication it should be indicated with the appropriate date and time. Record each medication name, dosage, and if/when a refill is due. If doses are to be given at school, a separate form should be maintained there. Information and observations such as side effects to watch for, reactions, or changes in medication should also be recorded on the form including the dates of each. Remember to get medication changes in writing from the doctor and ask that the medication label be changed as needed.

The following are also to be recorded on the form:
   a. Missed doses
   b. When a child refuses a dose
   c. When medication is destroyed

Notify the prescribing physician and the child’s Social Service Worker if a medication dose is missed or refused.

File the original in this section and provide a copy to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

Using the Form “Medication Transfer form” (DPP-106J)

Use this form when medicatons are transfered from your care. Please note that in addition to the original staying in this Medical Passport, a copy is to stay with the person releasing the medication(s) and a copy, with all signatures, goes to the child’s Social Service Worker.
Introduction:

Providing for the mental health care of all children in out-of-home care is as essential as the provision of proper medical and dental care.

From infancy, a child’s life becomes a complex and ever changing balance of systems interacting to form his or her environment. Child abuse and neglect place new forces on these systems, changing the balance and types of systems involved. Removal from the birth family home and placement into out-of-home care as a result of abuse, neglect, or dependency turns the child’s systems and environment, as they are known, entirely upside down. Family, friends, surroundings, and schools all change in some form or fashion, and the child is often left with little ability to understand and possible feelings of loss, guilt, anger, and despair. It is therefore recommended that all children in out-of-home care be evaluated to assess the need for mental health services and that they receive those needed for support during placement in out-of-home care.

Mental health services can assist children and youth in communicating their feelings about separation and loss by providing a neutral party (therapist / counselor) for discussion. Mental health services benefit both the child and Care Provider by addressing additional areas such as anger and behavior management, socialization, abuse recovery, school performance, and parenting issues. The Care Provider should see themselves as potentially the strongest change agent who has contact with the child. They need to form a team with the therapist to understand, support, and respond strategically to the child’s treatment issues.

When Should My Child Receive Mental Health Services?

Upon Entering Out-of-Home Care:

Arrangements should be made for an initial mental health screening to be performed by a qualified mental health professional for all children within 30 days of entering out-of-home care. It may be necessary for the child’s Social Service Worker to make the referral for this service due to contract agreements between the Department and mental health agencies. Therefore, Care Providers should discuss setting up the screening with the child’s worker prior to scheduling an appointment.

The mental health screening will serve to determine the child’s mental health needs. When the screening indicates that further assessment or treatment is necessary, the Social Service Worker makes arrangements and documents service provision. Arrangements are made for initial service provision within two working days of the receipt of information.

It will be helpful for the Care Provider and child’s Social Service Worker to share as much of the child’s history as possible with the mental health professional prior the assessment. This will help determine the method and techniques to be used and questions and topics to explore.

As Recommended By The Mental Health Professional:

Some mental health services may include brief or long term individual or group sessions, play therapy, art therapy, psychiatric services, testing, evaluation, medication, and medication management. Following an initial assessment, the mental health professional will recommend what services should be provided and the frequency.

Most children participate in sessions weekly or twice monthly, while others may attend sessions daily, twice, weekly, or monthly. The frequency of services may often change during particular periods of stress or success. Periodic breaks in services may also be taken when a child has resolved his current issues or is not making progress.

Care Providers and Social Service Workers should work with the mental health professional to determine the best frequency for the child. Care Providers and workers may need to share transportation responsibility to enable the child to attend sessions as needed.

During Times of Crisis or Major Change:

Children and Care Providers need additional support during times of family crisis and change. At these times, Care Providers should schedule additional
sessions with the mental health professional if services are already in place or work with the child’s Social Service Worker to make a referral for services.

Some times of crisis and change may include:

- A negative visit with birth parents
- Death (of a birth or foster family member or pet)
- Marriage or divorce of birth or foster parents
- Disruption or change in placement
- Addition of new child to placement or movement of another from placement
- Change of Social Service Worker
- Change of permanency goal (i.e. termination of parental rights and movement toward adoption)
- School-based behavioral/emotional problems
- Suspension
- Legal issues (i.e. allegations against the child, criminal offenses, and preparation for court appearances)
- The onset of puberty

**Medication Management**

Children in out-of-home care who are on prescription medication for behavior management or for treatment of a psychiatric diagnosis will require periodic appointments with a psychiatrist for medication management and monitoring. These appointments will be in addition to sessions with therapists or counselors who are not physicians and cannot prescribe or medically monitor medication. Medication management appointments are often scheduled monthly or quarterly and usually coincide with the time that a prescription refill is due.

Care Providers should share information with the psychiatrist about the child such as any behavior changes, weight gain or loss, eating and sleep changes, and other medications the child is taking.

When psychotropic medications are being considered, the Care Provider should make every effort to inform the child’s parent(s) and Social Service Worker of the plan to use this type medication even before it is prescribed. If this is not possible, SOP states resource parents are to inform the agency (child’s Social service worker) within one (1) working day of any psychotropic medication prescribed for a child.

**Psychiatric Hospitalization**

Some children in out-of-home care may require temporary or longer term hospitalization in an acute psychiatric care facility or hospital.

The mental health professional and physician working with the child must make the recommendation and referral for hospitalization.

Once a child is admitted to a psychiatric hospital, it is essential that the Care Provider and child’s Social Service Worker be involved as members of the treatment team. Care Providers who are planning to have the child return to their homes / facilities should take an active role in “parent” groups, visitation, and other support sessions provided. This will assist in planning for the child’s discharge and success in treatment.

**Using the Form “Mental Health Services” (DPP-106G)**

This form is to be filled out in its entirety at each counseling / therapy session and medication management appointment. Care Providers should fill in the child’s name, date of birth, therapist or counselor’s name and telephone number, psychiatrist’s name and telephone number, and the date of the session or appointment. Mental health professionals are to fill in the remaining information and sign the form. Remember to press firmly.

The form is separated into two sections: “Counseling / Therapy Session” and “Medication Management Appointment.” The Counseling / Therapy Session section must be filled out by the child’s counselor or therapist at each individual or group session, even if the information remains the same as the previous session.

The Medication Management Appointment section must be filled out by the psychiatrist / physician at each medication management appointment.

If you forget the forms, they may be filled out at a later date, however this can be burdensome. It may be helpful to leave a supply of blank forms in your car or with the mental health professional in the child’s record so that they will be available when needed.

Completed original forms should be filed in this section with a copy or the yellow copy given to the child’s Social Service Worker. If you do not have a resource to make photo copies, these may be made at your local DCBS office.

**Copies of Other Documents to be Included in this Section:**

- Mental Health Services Referrals
- Mental Health Evaluations/Psychological Testing
- DCBS Pediatric Symptom Checklists / Behavior Rating Scales
- School Psychoeducational Testing
- Behavior Management Plans
- Psychiatric Hospital Discharge Summaries
- Copy of psychotropic medications given by another physician
Introduction:

The term “medically fragile” is used to describe Kentucky’s children in out-of-home care who have a medical condition, documented by a physician, which can become unstable and change very quickly into a life-threatening situation. SOP lists some conditions that may require designation as medically fragile.

For a child to become designated as Medically Fragile the child’s Social Service Worker must seek approval. The Medical Support Section in DCBS’ Central office will review and advise the Regional Staff of eligibility. If a child is designated Medically Fragile there are additional Standards of Practice that become important. Each region has a designated Medically Fragile Liaison who will assist the Social Service Worker in ensuring that the child’s medical needs are addressed.

Preparation to Care for Medically Fragile Children

Initial and ongoing training for the medical fragile foster parent certification consists of the following:
- Join Hands Together training (14 hours) with two hour online pre-requisite and obtain Infant, Child and Adult CPR and First Aid is initially required
- Annual training offered twice a year in a conference style setting which provides the 16 hours required in:
  1. Growth and Development
  2. Nutrition
  3. Medical Disabilities
- DCBS medically fragile foster homes must complete annual training hours by the date they initially became a foster parent
- PCC/PCP medical fragile foster homes must complete annual training hours by the date they became a medically fragile foster parent
- Infant, Child and Adult CPR and First Aid must be kept current according to certification date

Placement of Medically Fragile Children

A child who is designated as medically fragile should be placed in a resource home that is approved to care for medically fragile children. This involves additional training and/or a nursing degree.

Consultation regarding designation should occur before a child is placed to ensure the appropriate home is identified for the child’s specific medical needs.

Individual Health Plans

Each Medically Fragile child is to have an “Individual Health Plan (IHP)” to be completed with input from the birth parents, resource parents, medical/rehabilitative health Care Providers. A copy of this IHP is to be kept in the passport as well as sent to the Regional Medically Fragile Liaison. The IHP is to be reviewed quarterly and reevaluated every six months.

During the IHP a decision will be made whether the child continues to need the medical fragile designation. The DCBS Medical Support Section staff will assist and provide consultation.

The Monthly Report

Resource parents or other Care Providers of medically fragile children are to submit monthly reports (see sample form). These will be submitted to the child’s Social Service Worker and then forwarded to the Medically Fragile Liaison. Please include information such as diagnosis medications, therapies, appointments, specialists seen, procedures completed or planned, hospitalizations, height and weight, new developments, and any other pertinent information or changes occurring during the month. If you do not already have a preferred format, a reproducible sample report form is printed on the back of this page. The child’s monthly report information may in fact need more space than that which is provided in the sample. Please use additional sheets or redesign your own form including the same information as needed. File copies of your reports in this section.

Copies of Other Documents to be Included in this Section:
- Therapy Notes
- Tube Feeding Flow Sheets for Intake Monitoring
- Infant Stimulation Notes
- Articles and Pamphlets Specific to Child’s Condition
- Apnea Alarm / Event Records
- Education / IEP Plans Outlining Medical Adaptations for the Child During School
MEDICALLY FRAGILE MONTHLY REPORT

DATE: ______________________

Child’s Name: ____________________ Child’s Birthdate: ________________

Foster Home: ____________________ Date of Placement: ________________

Child’s Weight: ________________ Height/Length: ________________

I. Overall Diagnosis and Care Needs:

____________________________________________________________________

____________________________________________________________________

II. Medications:

____________________________________________________________________

____________________________________________________________________

III. Physician(s) Name(s): ____________________ Area of Specialty:

____________________________________________________________________

____________________________________________________________________

IV. Medical Appointments: Most Recent and Future:

____________________________________________________________________

____________________________________________________________________

V. Change to Medications:

____________________________________________________________________

____________________________________________________________________

VI. Daily Medical Procedures/Treatment:

____________________________________________________________________

____________________________________________________________________

VII. Nutrition/Feeding Procedure:

____________________________________________________________________

____________________________________________________________________

VIII. Medical Emergencies since Last Monthly Report:

____________________________________________________________________

IX. Services: Therapies (O.T., P.T., Speech, Infant Stimulation):

____________________________________________________________________

Medical Equipment Company: ____________________

School: ____________________

Commission Nurse Visit: ________________ Home Health Visit: ________________

Counseling: ____________________

X. Family Visits: ____________________

XI. Comments or Concerns:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Foster Parent Signature, Date ____________________ Phone Number/Email Address ____________________

Provide Original to child’s Social Service Worker. Child’s Social Service Worker sends a copy to: Medically Fragile Liaison, R&C Worker and Designated CC SCHN nurse.
Introduction:

There is a strong likelihood that children in out of home care have been endangered due to exposure to drugs or drug environments. Such exposure may make the child more vulnerable to certain medical, mental/emotional and developmental problems. It is therefore important that screenings, assessments, exams and interventions are administered at particular intervals following the drug exposure.

Responses:

Children may respond differently to environmental drug exposure based on:

- The age of the child,
- The length of exposure,
- Chemicals to which they are exposed,
- The individual child’s physical functioning,
- The type of exposure (airborne toxins, direct skin contact, ingestions, injections), and/or
- Familial life style issues

Caution!

You should avoid quick conclusions concerning the origin of many physical, developmental, and behavioral symptoms exhibited by these children. Many of the damaging effects of abuse and neglect will contribute to some of the same symptoms. A medical assessment is needed to make the determination if intervention is appropriate.

Methamphetamine:

If the child was removed from a methamphetamine production site (lab), they should have been examined and screened at a hospital emergency room prior to coming to your home. The child should also have been showered or bathed and put in clean clothing, including shoes, at the hospital or at the removal site. If this procedure has been followed, the child should present no contamination risk to you or your family. (CHILD(REN) EXPOSED TO METHAMPHETAMINE PRODUCTION (METH LAB) INVESTIGATIONS) contains the procedures a worker is to follow when removing a child from a meth contaminated environment.

During the visit to the hospital emergency room, a health provider should:

1. obtain a urine sample, preferably within 2 hours (possibly up to 12 hours),
2. perform a medical assessment prior to placement and
3. assure a complete change of clean clothing for the child.

If a child is placed without this occurring, don’t panic. The resource home can simply wash the child with soap and water, discard the old clothing, including shoes, and provide new clothing.

The resource parent needs to know the plan for a continued medical and developmental assessment. This plan also needs to be shared with the health care providers for their education. The medical and developmental assessment is contained on the Drug Endangered Child form.
Although exposure to any drug environment creates risks for children, methamphetamine exposure (presence in a meth lab or presence when meth is being smoked) poses, perhaps, the most immediate physical risk. Some meth exposed children may experience:

- respiratory problems (some will exhibit asthma-like symptoms),
- irritation of the eyes, nose, and bronchial system,
- decreased appetite,
- increased heart rate,
- abnormally high body temperature,
- rashes or rash like lesions,
- abdominal pain, vomiting, and/or diarrhea,
- vacillations between sleepiness or exaggerated activity,
- language delay (for very young children) and other learning problems,
- some potential memory problems,
- depression and withdrawal,
- decreased attention span and concentration problems,
- mood swings,
- guilt or
- shame

Many of these symptoms may be short term and the child may normalize quickly after removal from the toxic environment. It is unknown at this time if exposure to drugs or dangerous chemicals used to produce methamphetamine will have long term implications. This is part of the reason it is important to carefully follow the accompanying medical and developmental routine.

**Using the Form “Methamphetamine Exposure Medical Evaluation and Follow-Up” (DPP-106I)**

All children that have been exposed to methamphetamine, or the chemicals used to produce methamphetamine, shall be taken to an emergency room or appropriate medical facility for a complete medical assessment. At the time of the initial evaluation, the State Social Services Worker completes the DPP106I Methamphetamine Exposure Medical Evaluation and Follow-Up Form.

**Note for State Social Services workers:**
The Methamphetamine Exposure Forms may be accessed from the on line policy manual. The link to the on-line policy manual is:

http://manuals.sp.chfs.ky.gov/Pages/index.aspx

Click the “Forms Browser” link on the bottom of the main page under “Content”. On the forms page you may find the form by its number - DPP-106I or by it name “Methamphetamine Exposure Form.” Please check SOP often for changes in the protocol for dealing with methamphetamine exposed children.

**Notes:**
Immediate Response:

Assessment
Assess the child or vulnerable adult for obvious injury or distress; if any of the below examples are noted, ACTIVATE EMS IMMEDIATELY.

Examples include but are not limited to:
- Rapid Breathing
- Difficulty Breathing
- Appears ill
- Injuries that are worrisome such as burns
- Lethargy (sluggishness, apathy)
- Somnolence (Sleepy or Drowsy)
- If there is an explosion
- If there are active chemicals at the scene
- EMS, if contacted, will make decisions regarding need for emergent intervention including full documentation

Cleansing or Containment
- Should occur prior to transport
- Gloves should be worn so as not to expose worker
- Clothing should be removed
- Cleanse the hair and skin to child or vulnerable adult. A warm shower is adequate and preferable to a bath
- New clothing should be given to child or vulnerable adult as all the clothing inside the area where the methamphetamine lab is located is considered contaminated.
- If unable to cleanse, place a sheet on car seat for transport to an acceptable facility

Collect
- Collect urine from potentially exposed children and vulnerable adults as soon as possible, preferably within 2 hours of removal
- Urine should be screened quantitatively for drugs of abuse (this should indicate the number of particles found not just positive or negative results)
- There are NO ACCEPTABLE levels of methamphetamine in children.

Within 2-4 hours:

Medical Examination
- The child or vulnerable adult should be evaluated in Emergency Room, Physician’s Office, etc. by a qualified medical professional.
- Includes vital signs, a thorough lung examination, respiratory rate and oxygen saturation on room air.
- Blood tests: CBC with Differential, Chemistry Panel to include BUN and Creatinine and Liver Panel
- In children and vulnerable adults a chest x-ray, 12 lead EKG and pulmonary function tests if clinically indicated

Within 72 hours:

- If Liver Panel is elevated, Hepatitis B and C panels should be evaluated.
- Mental Health Evaluation
- Dental evaluation
- For children, a developmental evaluation with special attention to speech, language and motor skills

Follow up:
- For children, repeat the medical examination in 30 days, 6 months and 1 year.
- A medical examination follow-up for vulnerable adults is at the discretion of their medical practitioner as some vulnerable and elderly adults may be more sensitive to cardiac and respiratory effects of methamphetamine chemicals.
- For children, follow-up developmental recommendations as needed
- In both children and vulnerable adults follow-up mental health recommendations as needed.
Kentucky Revised National Protocol for Medical Evaluation of Children Found in Methamphetamine Drug Labs
With Addendum for Vulnerable Adults
November 1, 2005

For the Emergency Department of Physician’s Office

Immediate Response:

Children should have at least a preliminary decontamination at the scene to include removal of clothing and cleansing of hair and skin before transport.

Medical Examination:

- Complete Medical Examination to assess Acute Medical Needs
- Urine for Toxicology (quantitative) COLLECTED AS SOON AS POSSIBLE, PREFERABLY WITHIN 2 HOURS, should be submitted to a lab that screens and reports for the level of detection and not just NIDA standards. Chain of evidence forms may be utilized of usual medical protocols for toxicology screens should be followed.
- Thorough Pulmonary Examination (minimum standard for the symptomatic child):
  - Vital signs
  - Respiratory Rate
  - O2 Saturation
  - CXR
- Labs (can be done acutely or within 72 hours):
  - CBC with Differential
  - Chemistry Panel to include BUN and Creatinine
  - Liver Function Test

Vulnerable adults, including the elderly, may be more sensitive than children to the cardiac and respiratory effects of toxins found in a methamphetamine lab. O2 sats, ECG and CXR are recommended.
<table>
<thead>
<tr>
<th>FORM NAME</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Authorization For Medical Treatment”</td>
<td>DPP-106A</td>
</tr>
<tr>
<td>“Initial Health Interview with Family”</td>
<td>DPP-106B</td>
</tr>
<tr>
<td>“Child Medical History and Annual Physical Exam”</td>
<td>DPP-106C</td>
</tr>
<tr>
<td>“Medical Appointment”</td>
<td>DPP-106D</td>
</tr>
<tr>
<td>“Dental Care”</td>
<td>DPP-106E</td>
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<tr>
<td>“Visual Screening”</td>
<td>DPP-106F</td>
</tr>
<tr>
<td>“Mental Health Services”</td>
<td>DPP-106G</td>
</tr>
<tr>
<td>“Prescription and OTC Medication Administration”</td>
<td>DPP-106H</td>
</tr>
<tr>
<td>“Methamphetamine Exposure Medical Evaluation and Follow-up” (if applicable)</td>
<td>DPP-106I</td>
</tr>
<tr>
<td>“Medication Transfer Form”</td>
<td>DPP-106J</td>
</tr>
</tbody>
</table>
AUTHORIZATION FOR MEDICAL TREATMENT
Indicate the most recent type of custody and date

VOLUNTARY COMMITMENT
The child identified below is under a voluntary commitment to the Cabinet for Health and Family Services, Department for Community Based Services (DCBS). Under a voluntary commitment, the parents authorize the Department to provide such medical care as may be advised by the attending physician except in cases of serious illness or major surgery. In these instances, the parents are to be contacted and their written consent obtained. A representative of the Department case worker may consent when parents cannot be located. In an emergency, if the case worker cannot be located, the foster parents may authorize emergency medical treatment.

TEMPORARY OR EMERGENCY CUSTODY
The child identified below is in the temporary or emergency custody of the Cabinet for Health and Family Services, Department for Community Based Services (DCBS), and a parent or district judge shall provide written approval for medical procedures. In an emergency, when the child requires immediate medical attention and the parent or judge has not granted prior written approval, or cannot be located, the case worker can authorize treatment. If the case worker cannot be located, the foster parents may authorize medical treatment.

COMMITMENT
The child identified below is committed to the Cabinet for Health and Family Services, Department for Community Based Services (DCBS). When any medical services are to be provided, a representative of the Cabinet, such as the child's case worker, or the parent, may approve services for the child by his or her signature. In an emergency, when the child needs immediate medical treatment, and the case worker cannot be notified, the foster parent may authorize treatment.

RIGHTS TERMINATED
The parental rights of the child identified below have been terminated. When any medical services are to be provided, a representative of the Cabinet, such as the child's caseworker, may approve the service for the child by his signature. In an emergency, when a child needs immediate medical attention and the case worker cannot be located, the foster parent may authorize medical treatment.

CHILD'S NAME: _______________________________________
DATE OF BIRTH: _______________________________________
DCBS WORKER: _______________________________________
WORK PHONE: _______________________________________
HOME PHONE: _______________________________________
DCBS SUPERVISOR: _______________________________________
WORK PHONE: _______________________________________
HOME PHONE: _______________________________________

File: Original in Passport Folder
Copy in Professional Section
INITIAL HEALTH HISTORY INTERVIEW WITH FAMILY

CHILD'S NAME_________________________________________________________ DOB:_________________

INFORMATION PROVIDED BY:________________________________________ DATE:_________________

CURRENT MEDICAL CONDITIONS

<table>
<thead>
<tr>
<th>Current Medical Condition</th>
<th>Physician Responsible</th>
<th>Treatment/Medical Equipment</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

DOES THIS CHILD HAVE ANY DRUG ALLERGIES? (LIST)_____________________________________________________

DOES THIS CHILD HAVE ANY FOOD ALLERGIES? (LIST)_____________________________________________________

DOES THIS CHILD HAVE ANY ENVIRONMENTAL ALLERGIES (Poison Ivy, Bee Stings, etc)? _________________________

Where has this Child most recently received routine medical care?:________________________________________

Date of most recent office visit and reason:________________________________________________________________

Are this child’s immunizations up to date:_________________ (obtain copy of immunization record if available)

Is this child on any medication? _____________ If yes please list

CURRENT MEDICATIONS:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Reason</th>
<th>Prescribed by</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Check, and describe if the child has any difficulties the following areas:

- SKIN
- NEUROLOGICAL
- VISUAL (EYES AND VISION)
- AUDITORY (EARS AND HEARING)
- MOUTH, NOSE AND SINUSES
- RESPIRATORY (BREATHING)
- CARDIOVASCULAR (HEART)

Describe:__________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

BIRTH HISTORY:

Name(location)of hospital where child was born________________________________________________________

Did this child have any prenatal complications? (Describe)________________________________________________________________

At what gestational age was this child born? (Describe) _________________________ Birth Weight ____________

Did this child have any complications of birth? (Describe)________________________________________________________________

Was this child exposed to tobacco, alcohol or other drugs during pregnancy? (Describe)______________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

File: Original in Passport Folder
Copy in Professional Section
DEVELOPMENTAL HISTORY:
Did/Does this child have any delays in reaching motor milestones such as sitting or walking? (Describe) _____
__________________________________________________________________________________________
Did/Does this child have any delays in learning to talk at appropriate ages? (Describe)________________
__________________________________________________________________________________________

HOSPITALIZATIONS:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
<th>Hospital, Location</th>
<th>Doctor(S)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

CURRENT MEDICAL PROVIDERS (Include Mental health care providers):

<table>
<thead>
<tr>
<th>Date Last Seen</th>
<th>Condition Treated</th>
<th>Doctor, Location</th>
<th>Specialty (i.e. cardiology, ENT)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

DOES THIS CHILD’S FAMILY (MATERNAL OR PATERNAL) HAVE ANY HISTORY OF SIGNIFICANT MEDICAL CONDITIONS THAT CAN BE HEREDITARY (LIKE SICKLE CELL, CYSTIC FIBROSIS, HEART DISEASE, ETC.):
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

PLEASE DESCRIBE ANY CONCERNS THAT YOU HAVE REGARDING THE HEALTH OF THIS CHILD:
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

BLOOD TYPE:
☐ O+  ☐ A+  ☐ B+  ☐ AB  ☐ O−  ☐ A−  ☐ B−  ☐ AB−

<table>
<thead>
<tr>
<th>Signatures</th>
<th>Relationship to Child:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td>Name:  Signature:</td>
</tr>
<tr>
<td>DCBS Staff</td>
<td>Name:  Signature:</td>
</tr>
</tbody>
</table>
**CHILD MEDICAL HISTORY AND ANNUAL PHYSICAL EXAM**

---

**Child Name (First, Middle, Last)**  
**Date of Birth**  
**Today's Date**

**Female**  
**Male**  
**Gender (Circle One)**  
**Twist Individual ID number**

**Case Name**

---

**SECTION I: this section to be completed by parent/DCBS staff and/or foster parent with the help of a medical professional present at the physical. Information from DPP-106B should be incorporated if applicable.**

**BIRTH HISTORY:**

In what city and state was the child born? (Describe)

In what hospital was the child born? (Describe)

Did this child have any prenatal complications? (Describe)

At what gestational age was this child born? (Describe)  
Birth Weight

Did this child have any complications of birth? (Describe)

Was this child exposed to tobacco, alcohol or other drugs during pregnancy? (Describe)

---

**BLOOD TYPE:**

- O+
- A+
- B+
- AB
- O−
- A−
- B−
- AB−

---

**DEVELOPMENTAL HISTORY:**

Did/Does this child have any delays in reaching motor milestones such as sitting or walking? (Describe)

Did/Does this child have any delays in learning to talk at appropriate ages? (Describe)

---

**CURRENT MEDICATION:**

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<tr>
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</tbody>
</table>

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**DOES THIS CHILD HAVE ANY DRUG ALLERGIES? (LIST)**

**DOES THIS CHILD HAVE ANY FOOD ALLERGIES? (LIST)**

**DOES THIS CHILD HAVE ANY ENVIRONMENTAL ALLERGIES (POISON IVY, Bee Stings, etc)?**

---

**HOSPITALIZATIONS:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital, Location</th>
<th>Doctor(S)</th>
<th>Reason</th>
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</thead>
<tbody>
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</tbody>
</table>

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**CURRENT MEDICAL PROVIDERS: (Include Mental health care providers)**

<table>
<thead>
<tr>
<th>Date Last Seen</th>
<th>Doctor, Location</th>
<th>Specialty (i.e. cardiology, ENT, )</th>
<th>Condition Treated</th>
</tr>
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<tbody>
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</tr>
</tbody>
</table>
**Does this child have any need for specialized medical equipment? (describe):**

<table>
<thead>
<tr>
<th>SKIN:</th>
<th>NEUROLOGICAL:</th>
<th>RESPIRATORY: (Breathing and Lungs)</th>
<th>MUSCULOSKELETAL: (Muscles and Bones)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Difficulties</td>
<td>No Difficulties</td>
<td>No Difficulties</td>
<td>No Difficulties</td>
</tr>
<tr>
<td>MRSA</td>
<td>Seizures</td>
<td>Smoking</td>
<td>Joint Pains/Swelling</td>
</tr>
<tr>
<td>Eczema/Dry Skin</td>
<td>Head Injury</td>
<td>Chronic Cough</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Bruising</td>
<td>Cerebral Palsy</td>
<td>Pneumonia</td>
<td>Congenital Deformities</td>
</tr>
<tr>
<td>Warts/lesions</td>
<td>Movement Disorder</td>
<td>History of TB or + Skin test</td>
<td>Amputations</td>
</tr>
<tr>
<td>Burns</td>
<td>Frequent/Recurrent Headache</td>
<td>Asthma</td>
<td>Broken Bones</td>
</tr>
<tr>
<td>Hair/Nail Problems</td>
<td>Dizziness</td>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>Scars</td>
<td>Other Neurological</td>
<td>Comments:</td>
<td>Comments:</td>
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</table>

**Comments:_________________________**

<table>
<thead>
<tr>
<th>MOUTH, NOSE AND SINUSES:</th>
<th>GASTROINTESTINAL: (Stomach and Digestion)</th>
<th>CARDIOVASCULAR: (Heart, Arteries and Veins)</th>
<th>GENITOURINARY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Difficulties</td>
<td>No Difficulties</td>
<td>No Difficulties</td>
<td>No Difficulties</td>
</tr>
<tr>
<td>Nosebleeds</td>
<td>Constipation</td>
<td>Heart Murmur</td>
<td>Enuresis (wetting)</td>
</tr>
<tr>
<td>Sinus Infections</td>
<td>Diarrhea</td>
<td>Heart Surgery</td>
<td>Infections</td>
</tr>
<tr>
<td>Tonsillectomy/Adenoidectomy</td>
<td>Vomiting</td>
<td>Arrhythmia</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>Recurrent Sore throat</td>
<td>Encopresis (soiling)</td>
<td>High Blood Pressure</td>
<td>Male:</td>
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<tr>
<td>Dental</td>
<td>Ulcer</td>
<td>Shortness of Breath</td>
<td>Penile Discharge</td>
</tr>
<tr>
<td>Comments:</td>
<td>Other GI</td>
<td>Bleeding disorder</td>
<td>Testicular Pain/Swelling</td>
</tr>
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**Comments:_________________________**

<table>
<thead>
<tr>
<th>MENTAL HEALTH:</th>
<th>SUBSTANCE ABUSE:</th>
<th>NUTRITIONAL: (Food and Diet)</th>
<th>VISUAL: (Eyes and Vision)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Difficulties</td>
<td>No Difficulties</td>
<td>Overweight</td>
<td>No Difficulties</td>
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<tr>
<td>The following must be supported by a medical profession’s diagnosis:</td>
<td>Alcohol Abuse</td>
<td>Underweight</td>
<td>Blindness</td>
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<tr>
<td>Depressed Mood</td>
<td>Marijuana Abuse</td>
<td>Food Intolerance</td>
<td>Eyeglasses</td>
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<tr>
<td>Bipolar Disorder</td>
<td>Other Drug Abuse</td>
<td>Anorexia</td>
<td>Other Visual</td>
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<tr>
<td>Anxiety/Panic</td>
<td>Other</td>
<td>Bulimia</td>
<td>Comments: _______________________</td>
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<tr>
<td>Obsessive/Compulsive</td>
<td>Comments:</td>
<td>Feeding tube</td>
<td>______________________</td>
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<tr>
<td>Attention Deficit Hyperactivity</td>
<td>Comments:</td>
<td>Other</td>
<td>______________________</td>
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<tr>
<td>Eating Disorder</td>
<td>Comments:</td>
<td>Other</td>
<td>______________________</td>
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<tr>
<td>Learning Disorder</td>
<td>Comments:</td>
<td>HEMATOLOGICAL: (Blood)</td>
<td>AUDITORY: (Ears and Hearing)</td>
</tr>
<tr>
<td>Autism</td>
<td>Comments:</td>
<td>No Difficulties</td>
<td>No Difficulties</td>
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<tr>
<td>Mental Retardation</td>
<td>No Difficulties</td>
<td>Diabetes Type 1</td>
<td>Hearing Loss</td>
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<tr>
<td>Out of Control Behavior</td>
<td>Anemia</td>
<td>Diabetes Type 2</td>
<td>Ear Tubes</td>
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<tr>
<td>Other Mental Health</td>
<td>Bleeding</td>
<td>Growth Problems</td>
<td>Other Auditory</td>
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<td>Sexual Abuse Victim</td>
<td>Leukemia</td>
<td>Other Endocrine</td>
<td>Hearing Aid(s)</td>
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<td>Comments:</td>
<td>Leukemia</td>
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<td>Comments: _______________________</td>
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**Comments:_________________________**

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<th>ENDOCRINE (Glands and Hormones):</th>
<th>AUDITORY: (Ears and Hearing)</th>
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<tr>
<td>Anemia</td>
<td>Diabetes Type 1</td>
<td>Hearing Loss</td>
</tr>
<tr>
<td>Bleeding</td>
<td>Diabetes Type 2</td>
<td>Ear Tubes</td>
</tr>
<tr>
<td>Leukemia</td>
<td>Growth Problems</td>
<td>Other Auditory</td>
</tr>
<tr>
<td>Comments:</td>
<td>Other Endocrine</td>
<td>Hearing Aid(s)</td>
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**Comments:_________________________**

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<tbody>
<tr>
<td>Birth Parent</td>
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<tr>
<td>Social Worker</td>
<td>□</td>
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<tr>
<td>Foster Parent/Caretaker</td>
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File Original Passport; Copy, Professional Section
### SECTION II: THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER

<table>
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<tr>
<th>EXAM</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
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<tr>
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<td>Abdomen</td>
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<td>Extremities</td>
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<td>Skin</td>
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<td>Other</td>
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**DEVELOPMENTAL**

- GROSS MOTOR:
- FINE MOTOR:
- LANGUAGE:
- PERSONAL SOCIAL:

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Right</th>
<th>Left</th>
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<tbody>
<tr>
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<tr>
<td>3000</td>
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</table>

**Vision**

- Right
- Left
- Both

Based on your observations, do you think this child needs referrals for other medical or psychiatric/therapeutic services?  
☐ Yes  ☐ No  If Yes, please describe: ____________________________________________________________  
__________________________________________________________________________________________  
__________________________________________________________________________________________

Based on your observations, do you think this child has any specialized needs?  
☐ Yes  ☐ No  If Yes, please describe:  
__________________________________________________________________________________________  
__________________________________________________________________________________________  
__________________________________________________________________________________________
TODAY'S DATE: __________________
CHILD'S NAME: ________________________________  DOB: _________________________
DCBS CASE NUMBER: _______________________________
REASON FOR VISIT: ___________________________________________________________________

Exam: (Please Describe any abnormal findings):       Wt:                                  Height: 
Temp:                   B/P:                      Pulse

Findings/Diagnosis

Recommendations

Follow-up:

Signatures

Health Care Provider
Name:
Signature:

Attending Appointment with Child (as appropriate)

Birth Parent
Name:
Signature

Foster Parent
Name:
Signature:

DCBS
Name:
Signature:

File Original in Passport Folder
Copy, Professional Section
CHILD'S NAME: ____________________________________________ DOB: ___________________________

DATE OF EXAMINATION: ___________________________________________________________________

GENERAL APPEARANCE OF TEETH AND MOUTH: ____________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

M: (missing)    X:  (extraction indicated)
BLUE color represents restoration present
RED color represents restoration needed

<table>
<thead>
<tr>
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</table>

UPPER PERMANENT BUCCAL LINGUAL

RIGHT DISTAL MESIAL DISTAL
A B C D E F G H I J

DECIDUOUS TEETH
T S R Q P O N M L K

LOWER TEETH LINGUAL BUCCAL

32 31 30 29 28 27 26 25
19 18 17 24 23 22 21 20

DOES CHILD NEED FOLLOW-UP APPOINTMENT? YES ______________ NO ____________________

WHY? __________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

DATE OF CHILD'S NEXT APPOINTMENT: _________________________________________

DENTIST'S SIGNATURE: _____________________________________________________

ADDRESS: __________________________________________________________________
PHONE: ____________________________________________________________________

File Original, Passport Folder
Copy, Professional Section
VISION SCREENING

CHILD'S NAME: ___________________________________________ DOB: ____________________

DCBS CASE NUMBER: ____________________________________________

DATE OF EXAMINATION: ___________________________________________________________________

OBSERVATIONS AND/OR RESULTS: _________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

DOES CHILD NEED FOLLOW-UP APPOINTMENT?  YES __________________ NO ___________________

WHY? _____________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

DATE OF CHILD'S NEXT APPOINTMENT: _____________________________________________________

EXAMINER'S SIGNATURE: __________________________________________________________________

ADDRESS:    ________________________________________________________________

________________________________________________________________

PHONE:    ________________________________________________________________
DPP-106G
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
MENTAL HEALTH SERVICES

CHILD'S NAME: ___________________________________________ DOB: ________________

THERAPIST / COUNSELOR: ___________________________________ Phone: ________________________

PSYCHIATRIST / PHYSICIAN: ________________________________ Phone: ________________________

COUNSELING / THERAPY SESSION

Date: _____________________________

Current frequency of appointments: Weekly: □ Twice Weekly: □ Other: ____________________________

Please rate the child's progress in meeting all goals on the following scale.

(Has Work To Do) 1 2 3 4 5 6 7 8 9 10 (Work Completed Successfully)

Current Psychiatric Medication If none, please indicate with a check here □

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Medication if needed</th>
<th>Dosage</th>
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</thead>
<tbody>
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</table>

A conference session with one or more of the individuals(s) circled below is needed. Please call to schedule.

Birth Parent Care Provider Family Services Worker Sibling Psychiatrist Other: __________________________

Homework Assignment: __________________________________________

Notes / Comments: _______________________________________________________________________________

________________________________________________________________________________________________

Therapist /Counselor Signature: _______________________________ Next Appointment: ______________

MEDICATION MANAGEMENT APPOINTMENT

Date: _____________________________

Height: ____________             Weight: ____________  Blood Pressure: ______________________

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Referral for Testing / Evaluation Needed (Please indicate Blood Work, MRI, CT Scan, Other): ___________________

Please Note: Birth parents and the family social service worker are to be notified of any change in medications. This includes dosage, stopping a medication or starting a new medication. If possible, make this notification prior to the change in medication.

Physician Signature: _______________________________ Next Appointment: _____________________________

File: Original in Passport Folder
Copy in Professional
# Medication Administration Form

For _____________________ (MONTH) of _________ (YEAR)

**Child’s Name:** ________________________________

**DOB:** _______

**Height:** _______

**Weight:** _______

**Med. Allergy/Reaction** ________________

---

**EACH time you give a child their medication please remember the “Six Rights of Medication Administration”**

1. **Right Person**  
2. **Right Medication**  
3. **Right Dosage**  
4. **Right Route**  
5. **Right Time**  
6. **Right Documentation**

---

<table>
<thead>
<tr>
<th>Medication 1 Details</th>
<th>Time Given</th>
<th>Day (initial the box as medication is given)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
<td>1  2  3  4 5  6  7  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25  26  27  28  29  30  31</td>
<td></td>
</tr>
<tr>
<td>Dose:</td>
<td></td>
<td></td>
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<tr>
<td>For:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refill Date:</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication 2 Details</th>
<th>Time Given</th>
<th>Day (initial the box as medication is given)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
<td>1  2  3  4 5  6  7  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25  26  27  28  29  30  31</td>
<td></td>
</tr>
<tr>
<td>Dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refill Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication 3 Details</th>
<th>Time Given</th>
<th>Day (initial the box as medication is given)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
<td>1  2  3  4 5  6  7  8  9  10  11  12  13  14  15  16  17  18  19  20  21  22  23  24  25  26  27  28  29  30  31</td>
<td></td>
</tr>
<tr>
<td>Dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refill Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**File:** Original in Passport; Copy in Professional Section

**Your Initials = Med Taken**  
**Your Initials + R= Med refused**  
**Your Initials + M= Med Missed**

* Document on a separate page and notify physician and family social services worker that day.*
## Medication Administration Form

**For** _____________________ (MONTH) of_________(YEAR)

**Time** | **Given**
--- | ---

**Medication:**

<table>
<thead>
<tr>
<th><strong>Day</strong> (initial the box as medication is given)</th>
<th><strong>Initials</strong></th>
<th><strong>Refill Date:</strong></th>
<th><strong>For:</strong></th>
<th><strong>Dose:</strong></th>
</tr>
</thead>
</table>

**Resource Parent Signature:**

_____________________________________________________________________

___________

*Document on a separate page and notify physician and family social services worker that day.*

- Your initials = Med Taken
- Your initials + R = Med Refused
- Your initials + M = Med Missed

Disposal of unused or expired medication: (Do not flush the meds or pour down a drain)

---

Page 2 of 2
Methamphetamine Exposure Medical Evaluation and Follow-up Form

Form is to be completed by DCBS worker for the child at the time of each medical evaluation, regardless of custody status.

**CHILD’S NAME:** ____________________________________________ **DOB:** ____________________________

(please print) **DCBS WORKER:** ____________________________ **DCBS CASE NUMBER:** ____________________________

(please print)

NATURE OF DRUG EXPOSURE

<table>
<thead>
<tr>
<th>DATE OF EXPOSURE:</th>
<th>DURATION OF EXPOSURE:</th>
<th>DESCRIPTION OF CHILD’S EXPOSURE:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

CHILD REMOVED FROM METHAMPHETAMINE LAB

☐ Yes ☐ No

NATURE OF METH SITE:

☐ Fire at Site ☐ Explosion at Site ☐ Active Meth Cook at Site

☐ Smoking Meth at Site ☐ Other (Explain): ____________________

TYPE OF DECONTAMINATION:

☐ Clothes Changed at Site ☐ Showered at Site

☐ EMS Evaluated at Site ☐ Washed at Site

LEGAL STATUS: Active Criminal Investigation for Methamphetamine Related Charges

☐ Yes ☐ No If yes, current placement:

PLACEMENT STATUS: Child is in Out of Home Care

☐ Yes ☐ No

CPS STATUS:

☐ Physical Abuse Investigation Results: ____________________________ Date: ____________________________

☐ Sexual Abuse Investigation Results: ____________________________ Date: ____________________________

☐ Emotional Abuse Investigation Results: ____________________________ Date: ____________________________

☐ Neglect Investigation Results: ____________________________ Date: ____________________________

DCBS Central Office Notified of child’s status

☐ Yes ☐ No

Medical Passport Issued:

☐ Yes ☐ No

I. INITIAL EVALUATION (Within 2-4 hours)

Use DPP-106-D to document exam and recommendations (Note all bruises, burns, etc.)

**DATE:**

**NAME OF MEDICAL PROVIDER:**

SPECIAL ISSUES

Does child still need cleansing & clean clothes?

☐ Yes ☐ No

Does child show any breathing problems?

☐ Yes ☐ No

If yes, is Chest X-Ray Needed

☐ Yes ☐ No Pulse Oximetry

☐ Yes ☐ No

Urine for quantitative toxicology for Meth must be obtained. Please confirm this was obtained:

☐ Yes ☐ No

(Assess for all drugs of abuse. This should be done preferably within 2 hours of removal, but no later than up to 12 hours. Follow chain of custody.)

LAB TESTING

The physician may recommend the following:

CBC with diff.

☐ Yes ☐ No

Chemistry Panel with BUN/Creatine and Liver Function

☐ Yes ☐ No

The following should be considered:

Carboxyhemoglobin:

☐ Yes ☐ No

Hepatitis Profile:

☐ Yes ☐ No

Whole Blood Level:

☐ Yes ☐ No

HIV:

☐ Yes ☐ No

If clinically indicated, was 12 lead EKG and pulmonary function tests completed:

☐ Yes ☐ No

Document any bruises, burns, or injuries (consider referral to living forensics).

Consider child sexual abuse evaluation and cultures.

If evidence of physical abuse, consider Skeletal Survey for a child ages (3) three or older

Developmental Assessment, Mental Health Assessment and Dental Exam should be arranged.

(Follow up with medical provider in 72 hours.)

Please see the Kentucky Revised National Protocol for Medical Evaluation of Children Found in Methamphetamine Drug Labs (In Medical Passport or on CHFS intranet) for further information:

http://manuals.chfs.ky.gov/dcbs_manuals/dpp/docs/Meth%20Lab%20Handouts.doc

Original: File

Copies: Medical Provider

Medical Passport
II. FOLLOW-UP MEDICAL EVALUATION (Within 72 hours)

The main objective of this visit is to complete the evaluation initiated at 2 to 4 hours, review any results, and address any problems identified. If Urine drug testing (qualitative toxicology) was not obtained, then that should be obtained at this time. If child is still possibly in an environment with ongoing drug exposure then a repeat drug test should be obtained. If the liver panel is elevated, Hepatitis B and C panels should be elevated. Follow up in one month.

Current placement:__________________________________________________________
Developmental Assessment Date:_____________ Agency:__________________________
Mental Health Assessment Date:_____________ Agency:__________________________
Dental Assessment Date:____________________ Provider:__________________________
Obtain Height & Weight and Plot on Growth Chart  Height:____________ Weight:_________

II. FOLLOW-UP MEDICAL EVALUATION (Within 30 days)

DATE: __________________ NAME OF MEDICAL PROVIDER:__________________________
Use the DPP-106-D to document exam and recommendations
This visit is to follow-up on results of initial visits and review any problems identified with special focus on treatment and referral of any findings of developmental assessments, mental health assessments and dental exams. If the child is still possibly in an environment with ongoing drug exposure then repeat urine drug testing should be considered. Follow-up in 5 months.

Comments:_________________________________________________________________

IV. FOLLOW-UP MEDICAL EVALUATION (Within 6 months)

DATE: __________________ NAME OF MEDICAL PROVIDER:__________________________
Use the DPP-106D to document exam and recommendations
The purpose of this visit is to follow-up previous medical, developmental, mental health and dental problems identified in the previous 3 visits. It should be confirmed that copise of evaluations have been provided to the medical provider, are in the DCBS file and medical passport.

Current Placement of Child:______________________________ Relationship:____________
Comments:_________________________________________________________________

V. FOLLOW-UP MEDICAL EVALUATION (Within one year)

DATE: __________________ NAME OF MEDICAL PROVIDER:__________________________
Use the DPP 106D to document exam and recommendations
This visit is to ensure identified issues are being addressed and to monitor current health.
Recommended long-term follow-up:________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Medication Transfer Form

Instructions:
1. Use this form when medication is sent with a child/youth.
2. Fill in the child’s name, date of birth and the date the form is completed.
3. List the names of the medications and dosages being released, instructions on how and when they should be taken, the last time the medication was taken, the number of pills or number of bottles for liquids, or number of tubes for creams/ointments being sent and the number of refills left (enter a zero if none).
4. The care giver from the sending placement fills in the name and phone number of the family’s social service worker in case there are questions or discrepancies.
5. In the next box, the person releasing the medication signs and dates the form.
6. Then the transporting person (if applicable) signs and dates the form.
7. Finally the person receiving the medication signs and dates the form. The signatures mean the medication(s) and count(s) are correct.
8. The new caregiver should keep a copy of this form, a copy given to the family social service worker for the case file and the original kept in the Medical Passport.
9. Please print and sign legibly.

<table>
<thead>
<tr>
<th>Child/Youth’s Name</th>
<th>Social Service Worker’s Name</th>
<th>Social Service Worker’s Phone</th>
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</table>

The following medication(s) are being transferred:

<table>
<thead>
<tr>
<th>Prescribing Doctor’s Name</th>
<th>Doctor’s Phone Number</th>
<th>Medication, dosage and how to give the medication</th>
<th>Last Time Given</th>
<th>Number of pills/bottles/tubes</th>
<th>Number of refills left</th>
</tr>
</thead>
<tbody>
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By signing below you are agreeing that all medications and counts are accurate as listed above.

Signature of Person releasing medication ____________________________________________________________________________________ Date __________
Signature of Person transporting Medication ________________________________________________________________________________ Date __________
Signature of Person receiving the medication(s)______________________________________________________________________________ Date __________

Note: Some medication may not be in "child proof" containers. Please keep all medications out of the reach of children.
If there are questions or concerns related to this medication transfer, please contact your social service worker immediately.

File: Original in Medical Passport
Copy with person releasing medication(s) and
Copy with all signatures in Professional Section
ENCOMENDAMIENTO VOLUNTARIO

El niño identificado abajo está bajo el encomendamiento voluntario del Gabinete para Servicios de Salud y de la Familia, Departamento para Servicios Basados en la Comunidad (DCBS por sus siglas en inglés). Bajo el encomendamiento voluntario, los padres autorizan al Departamento para que provea cuidado médico tal como un doctor a cargo recomiende, con la excepción de los casos de enfermedad grave o cirugía mayor. En estos casos, se comunicarán con los padres y obtendrán su consentimiento por escrito. Un representante del trabajador de caso del Departamento puede dar el consentimiento cuando no se puede localizar a los padres. En caso de una emergencia, si no se puede localizar al trabajador de caso, los padres de crianza pueden autorizar el tratamiento médico de emergencia.

CUSTODIA TEMPORAL O DE EMERGENCIA

El niño identificado abajo está bajo la custodia temporal o de emergencia del Gabinete para Servicios de Salud y de la Familia, Departamento para Servicios Basados en la Comunidad (DCBS por sus siglas en inglés), y un padre o juez del distrito proporcionará aprobación por escrito para los procedimientos médicos. En caso de emergencia, cuando el niño requiera atención médica inmediata y el padre o juez no ha entregado aprobación por escrito anteriormente, o no se pueden localizar, el trabajador de caso puede autorizar el tratamiento. Si no se puede localizar al trabajador de caso, los padres de crianza pueden autorizar el tratamiento médico.

ENCOMENDAMIENTO

El niño identificado está encomendado con el Gabinete para Servicios de Salud y de la familia, Departamento para Servicios Basados en la Comunidad (DCBS por sus siglas en inglés). Cuando se tiene que proporcionar cualquier servicio médico, un representante del Gabinete, tal como el trabajador de caso del niño, o el padre/la madre, puede aprobar los servicios para el niño con su firma. En caso de emergencia, cuando el niño necesita tratamiento médico inmediato, y no se puede avisar al trabajador de caso, el padre de crianza puede autorizar el tratamiento.

DERECHOS TERMINADOS

Los derechos de los padres al niño identificado abajo han sido terminados. Cuando se proporcione cualquier servicio médico, un representante del Gabinete, tal como el trabajador de caso del niño, puede aprobar el servicio para el niño con su firma. En caso de emergencia, cuando el niño necesita atención médica inmediata y no se puede localizar al trabajador de caso, el padre de crianza puede autorizar el tratamiento médico.

NOMBRE DEL NIÑO: _______________________________________
FECHA DE NACIMIENTO: _______________________________________
TRABAJADOR DE DCBS: _______________________________________
TELÉFONO DE TRABAJO: _______________________________________
TELÉFONO DE CASA: _______________________________________
SUPERVISOR DE DCBS: _______________________________________
TELÉFONO DE TRABAJO: _______________________________________
TELÉFONO DE CASA: _______________________________________
ENTREVISTA INICIAL CON LA FAMILIA SOBRE EL HISTORIAL DE SALUD

NOMBRE DEL NIÑO: ____________________________________________________________
FECHA DE NACIMIENTO: ____________________________________________________
INFORMACIÓN PROPORCIONADA POR: ______________________________ FECHA: _______________

<table>
<thead>
<tr>
<th>Condición Médica Actual</th>
<th>Doctor Responsable</th>
<th>Tratamientos Haga una lista de los medicamentos abajo</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

¿TIENE ESTE NIÑO ALGUNA ALERGIA A MEDICINAS? (DÉ UNA LISA) _______________________
¿TIENE ESTE NIÑO ALGUNA ALERGIA A COMIDAS? (DÉ UNA LISTA) _______________________
¿TIENE ESTE NIÑO ALGUNA ALERGIA A FACTORES DEL AMBIENTE (Hiedra Venenosa, Picaduras de Abejas, etc)? ___________

¿En dónde ha este niño recibido atención médica de rutina más recientemente?: ____________________________________________
Fecha y razón de la visita más reciente al consultorio: ________________________________________________________________
¿Están actualizadas las inmunizaciones de este niño?: ____________________ (obtenga una copia del registro de inmunización si está disponible)
¿Toma este niño algún medicamento? _______ Si la respuesta es sí, favor de dar una lista

MEDICAMENTOS ACTUALES:

<table>
<thead>
<tr>
<th>Medicamento</th>
<th>Dosis</th>
<th>Razón</th>
<th>Recetado por</th>
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<tbody>
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</table>

Marque, y describa si el niño tiene alguna dificultad en las siguientes áreas:

☐ PIEL ☐ NUTRITIVO (ALIMENTOS Y DIETA)
☐ NEUROLÓGICO ☐ GASTROINTESTINAL (ESTÓMAGO Y DIGESTIÓN)
☐ VISUAL (OJOS Y VISTA) ☐ URINARIO (RIÑONES Y ORINA)
☐ AUDITIVO (OÍDOS Y AUDICIÓN) ☐ ENDOCRINO (GLÁNDULAS Y HORMONAS)
☐ BOCA, NARIZ Y SENOS NASALES ☐ MUSCULOSQUELÉTICO (MÚSCULOS Y HUESOS)
☐ RESPIRATORIO (RESPIRACIÓN) ☐ HEMATOLÓGICA (SANGRE):
☐ CARDIOVASCULAR (CORAZÓN) ☐ SALUD MENTAL/ABUSO DE DROGAS:

Describa: ____________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Medicamento | Dosis | Razón | Recetado por
-------------|-------|-------|--------------
HISTORIAL DE NACIMIENTO:
Nombre (ubicación) del hospital donde nació el niño ________________________________
¿Sufrió este niño alguna complicación prenatal? (Describa) ____________________________
¿En qué edad gestacional nació este niño? (Describa) _________________________________ Peso al Nacer ________
¿Sufrió este niño alguna complicación del parto? (Describa) ____________________________
¿Fue este niño expuesto al tabaco, alcohol u otra droga durante el embarazo? (Describa) __________

HISTORIAL DEL DESARROLLO:
¿Experimenta/Experimentó este niño algún retraso en alcanzar hitos motores tales como incorporarse o caminar? (Describa) ____________________________
¿Experimenta/Experimentó este niño algún retraso en aprender a hablar a las edades adecuadas? (Describa) ______

HOSPITALIZACIONES:

<table>
<thead>
<tr>
<th>Fecha</th>
<th>Hospital, Lugar</th>
<th>Razón</th>
<th>Doctor(es)</th>
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</thead>
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</tbody>
</table>

PROVEEDORES MÉDICOS ACTUALES (Incluya los proveedores de Cuidado de Salud Mental):

<table>
<thead>
<tr>
<th>Doctor, Lugar</th>
<th>Especialidad (i.e. cardiología, otorrinolaringólogo)</th>
<th>Condición Tratada</th>
<th>Última Visita</th>
</tr>
</thead>
<tbody>
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</table>

¿TIENE ESTE NIÑO NECESIDAD PARA EQUIPAMENTO MÉDICO ESPECIALIZADO? (DESCRIBA) ________________

¿TIENE LA FAMILIA (MATERNA O PATERNA) DE ESTE NIÑO ALGÚN HISTORIAL DE CONDICIONES MÉDICAS IMPORTANTES QUE PODRÍAN SER HEREDITARIAS (TALES COMO CÉLULA FALCIFORME, FIBROSIS QUÍSTICA, ENFERMEDADES CARDÍACAS, ETC.):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

POR FAVOR, DESCRIBA CUALQUIER INQUIETUD QUE TIENE USTED CON RESPETO A LA SALUD DE ESTE NIÑO:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

GRUPO SANGUÍNEO:
☐ O+ ☐ A+ ☐ B+ ☐ AB ☐ O− ☐ A− ☐ B− ☐ AB−

<table>
<thead>
<tr>
<th>Pariente</th>
<th>Nombre:</th>
<th>Parentesco con el Niño:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firma:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empleado de DCBS</td>
<td>Nombre:</td>
<td></td>
</tr>
<tr>
<td>Firma:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sistema</td>
<td>Estado</td>
<td>Comentarios</td>
</tr>
<tr>
<td>---------</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Piel</td>
<td>Ninguna dificultad</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Verrugas/lesiones</td>
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<tr>
<td></td>
<td>Condición infecciosa</td>
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<tr>
<td></td>
<td>Ecema/Piel seca</td>
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<tr>
<td>NEUROLÓGICO:</td>
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<td>Ninguna dificultad</td>
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<tr>
<td></td>
<td>Trastorno del Movimiento</td>
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<td>Herida de la Cabeza</td>
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<td>Parálisis cerebral</td>
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<td>VISUAL (OJOS Y VISTA):</td>
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<tr>
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<td>Ninguna dificultad</td>
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<tr>
<td></td>
<td>Ceguera</td>
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<td></td>
<td>Anteojos</td>
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<tr>
<td></td>
<td>Otro Problema Visual</td>
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</tr>
<tr>
<td>AUDITIVO (OÍDOS Y AUDICIÓN):</td>
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<tr>
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<td>Ninguna dificultad</td>
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<td>Pérdida de Audición</td>
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<td>Otro Problema Auditivo</td>
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<td>BOCA, NARIZ Y SENOS NASALES:</td>
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<td>Hemorragias nasales</td>
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<td>Infecciones del Seno Nasal</td>
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<tr>
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<td>Amigdalectomía/Adenoidectomía</td>
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<td></td>
<td>Dolor de garganta recurrente</td>
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<tr>
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<td>Dental</td>
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<tr>
<td>RESPIRATORIO (RESPIRACIÓN Y PULMONES):</td>
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<td></td>
</tr>
<tr>
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<td>Ninguna dificultad</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fumar</td>
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<td></td>
<td>Tos Crónico</td>
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<td></td>
<td>Pulmonía</td>
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<tr>
<td></td>
<td>Antecedentes de tuberculosis o Prueba de Piel +</td>
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<td>Asma</td>
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</tr>
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<td>Resfriados Frecuentes</td>
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<tr>
<td></td>
<td>Otro</td>
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<tr>
<td>CARDIOVASCULAR (CORAZÓN, ARTERIAS Y VENAS):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ninguna dificultad</td>
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<tr>
<td></td>
<td>Presión Arterial Elevada</td>
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<td>Soplo Cardíaco</td>
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<td>Cirugía al Corazón</td>
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<td>Arritmia</td>
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<tr>
<td></td>
<td>Falta de Aliento</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Otros Problemas Cardiovasculares</td>
<td></td>
</tr>
</tbody>
</table>
NUTRITIVO (ALIMENTOS Y DIETA):

☐ Sobrepeso ☐ Debajo de Peso Normal ☐ Intolerancia a la Comida ☐ Otro

Comentarios:

GASTROINTESTINAL (ESTÓMAGO Y DIGESTIÓN):

☐ Ninguna dificultad ☐ Estreñimiento ☐ Diarrea ☐ Vómitos
☐ Intolerancia a la Comida ☐ Encopresis (ensuciarse) ☐ Úlcera ☐ Otro gastrointestinal

Comentarios:

URINARIO (RIÑONES Y ORINA):

☐ Ninguna dificultad ☐ Orinarse de día/en la cama ☐ Infecciones ☐ Otro GU

Comentarios:

ENDOCRINO (GLÁNDULAS Y HORMONAS):

☐ Ninguna dificultad ☐ Diabetes ☐ Problemas de Crecimiento ☐ Otro endocrino

Comentarios:

MUSCULOESQUELÉTICO (MÚSCULOS Y HUESOS)

☐ Ninguna dificultad ☐ Dolor/Hinchazón de Articulaciones ☐ Escoliosis ☐ Dolor de Espalda
☐ Deformidades Congénitas ☐ Amputaciones ☐ Huesos Fracturados ☐ Otro

Comentarios:

GENITAL/REPRODUCTIVO:

☐ Enfermedad de Transmisión Sexual ☐ Víctima de Abuso Sexual ☐ Otro GU

Masculino: ☐ Flujo del Pene ☐ Dolor/Hinchazón Testicular
Femenina: ☐ Flujo Vaginal ☐ Dificultades Menstruales ☐ Embarazos ☐ Bulto en el Seno

Comentarios:

HEMATOLÓGICA (SANGRE):

☐ Ninguna dificultad ☐ Anemia ☐ Sangradoemia ☐ Leucemia

Comentarios:

SALUD MENTAL/ABUSO DE DROGAS:

☐ Ninguna dificultad ☐ Animo Deprimido ☐ Trastorno Bipolar ☐ Ansiedad/Pánicos
☐ Obsesivo/Compulsivo ☐ Déficit de Atención con Hiperactividad ☐ Trastorno Alimenticio ☐ Trastorno en el Aprendizaje
☐ Autismo ☐ Retrasos Mentales ☐ Comportamiento sin Control ☐ Otros Problemas de Salud Mental
☐ Abuso de Alcohol ☐ Abuso de Marihuana ☐ Abuso de Otras Drogas ☐ Otros Problemas de Salud Mental

Comentarios:

HISTORIAL DE NACIMIENTO:

¿En qué ciudad y estado nació el niño? (Describa) ____________________________________________________

¿En qué hospital nació el niño? (Describa) ______________________________________________________________

¿Sufrió este niño alguna complicación prenatal? (Describa) _____________________________________________

¿En qué edad gestacional nació este niño? (Describa) Peso al Nacer ________________________________

¿Sufrió este niño alguna complicación en el parto? (Describa) __________________________________________

¿Fue este niño expuesto al tabaco, alcohol u otra droga durante el embarazo? (Describa) ________________

Grupo Sanguíneo:

☐ O+ ☐ A+ ☐ B+ ☐ AB ☐ O- ☐ A- ☐ B- ☐ AB-
**HISTORIAL DEL DESARROLLO:**
¿Experimenta/Experimentó este niño algún retraso en alcanzar hitos motores tales como incorporarse o caminar? (Describa) ______
_____________________________________________________________________________________________
_____________________________________________________________________________________________
¿Experimenta/Experimentó este niño algún retraso en aprender a hablar en las edades adecuadas? (Describa) ___________
_____________________________________________________________________________________________

**MEDICAMENTOS ACTUALES:**

<table>
<thead>
<tr>
<th>Medicamento</th>
<th>Dosis</th>
<th>Razón</th>
<th>Recetado por</th>
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</thead>
<tbody>
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</tbody>
</table>

**¿TIENE ESTE NIÑO ALGUNA ALERGIA A MEDICINAS? (DÉ UNA LISTA)**

**¿TIENE ESTE NIÑO ALGUNA ALERGIA A COMIDAS? (DÉ UNA LISTA)**

**¿TIENE ESTE NIÑO ALGUNA ALERGIA A FACTORES DEL AMBIENTE (HIEDRA VENENOSA, Picaduras de Abejas, etc)?**

**HOSPITALIZACIONES:**

<table>
<thead>
<tr>
<th>Fecha:</th>
<th>Hospital, Lugar</th>
<th>Razón</th>
<th>Doctor(es)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**PROVEEDORES MÉDICOS ACTUALES: (Incluya los proveedores de Cuidado de Salud Mental)**

<table>
<thead>
<tr>
<th>Doctor, lugar</th>
<th>Especialidad (i.e. cardiología, otorrinolaringólogo)</th>
<th>Condición Tratada</th>
<th>Última Visita</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**¿TIENE ESTE NIÑO NECESIDAD DE EQUIPAMENTO MÉDICO ESPECIALIZADO? (DESCRIBA):**

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Firma: [___] Fecha: [___]

Llenado por: [___] Padre/mADRE [___] Padre de Crianza/Proveedor de Cuidado [___] Trabajador Social
### SECTION II: THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER
(SECCIÓN II: ESTA SECCIÓN SERÁ LLENADA POR EL PROVEEDOR MÉDICO)

| EXAM       | Ht: | Wt: | Temp | B/P | Pulse | NORMAL | ABNORMAL | NOT EXAMINED | COMMENTS/FINDINGS | DEVELOPMENTAL | GROSS MOTOR: | FINE MOTOR: | LANGUAGE: | PERSONAL SOCIAL: | HEARING | Right | Left |
|------------|-----|-----|------|-----|-------|--------|----------|--------------|------------------|----------------|----------------|-------------|-------------|------------|-----------|-----------------|---------|-------|------|
| General    |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| HEENT      |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Neck       |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Lungs      |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Heart      |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Abdomen    |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Genitalia  |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Nodes      |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Extremities|     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Neuro      |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Skin       |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |
| Other      |     |     |      |     |       |        |          |              |                  |                |               |             |            |             |               |         |       |      |

Based on your observations, do you think this child needs referrals for other medical or psychiatric/therapeutic services? ☐ Yes ☐ No If Yes, please describe: ______________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Based on your observations, do you think this child has any specialized needs due to any drug exposure?  ☐ Yes ☐ No If Yes, please describe: ______________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Findings:

____________________________________________________________________________________
____________________________________________________________________________________________
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization For Medical Treatment” DPP-106A</td>
<td>13</td>
</tr>
<tr>
<td>&quot;Child Medical History and Annual Physical Exam&quot;</td>
<td>16</td>
</tr>
<tr>
<td>DPP-106C</td>
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<tr>
<td>&quot;Dental Care&quot; DPP-106E</td>
<td>21</td>
</tr>
<tr>
<td>Forms - List with old numbers</td>
<td>2</td>
</tr>
<tr>
<td>Forms - Samples start after</td>
<td>36</td>
</tr>
<tr>
<td>Forms - Where to get more</td>
<td>2</td>
</tr>
<tr>
<td>Forms - Who gets copies</td>
<td>2</td>
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<tr>
<td>Immunization</td>
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<tr>
<td>&quot;Initial Health Interview with Family” DPP-106B</td>
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<tr>
<td>Insurance cards</td>
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<tr>
<td>&quot;Mental Health Services” DPP-106G</td>
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<tr>
<td>&quot;Medical Appointment” DPP-106D</td>
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<tr>
<td>Medically Fragile Monthly Report</td>
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<tr>
<td>Methamphetamine Exposure Medical Evaluation and Follow-Up - DPP106I</td>
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<tr>
<td>Over-The-Counter Medications</td>
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<tr>
<td>Payments</td>
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<tr>
<td>&quot;Prescription and OTC Medication Administration”</td>
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<tr>
<td>DPP-106H</td>
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<tr>
<td>&quot;Visual Screening” DPP-106F</td>
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</table>

This Medical Passport has been developed and produced by the University of Kentucky Training Resource Center Resource Parent Training Program in direct support of the Kentucky Department for Community Based Services.

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