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|  | **HEALTH SUMMARY** |

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| Case Name | |  | | | | | | | | | | | | | Case ID # | |  | |
| Child/Youth | |  | | | | | | | | | | | | | Child ID # | |  | |
| Child's Age | |  | | | | Child's D.O.B. | |  | | | | | | | Primary Language | |  | |
| Emergency Contact Name  & Relationship | | |  | | | | | | | | | | | Phone | |  | | |
|  | | | | | | | | | | | Phone | |  | | |
|  | | | | | | | | | | | | | | | | | | |
| **Current Health Care Providers** | | | | | | | | | | | | | | | | | | |
| **Provider Type** | | | | **Name** | | | | | | | | | | **Phone** | | | | **Last Exam/Visit** |
| Primary Care  Medical Provider | | | |  | | | | | | | | | |  | | | |  |
| Dentist | | | |  | | | | | | | | | |  | | | |  |
| Mental/ Behavioral Health Professional | Psychiatrist | | |  | | | | | | | | | |  | | | |  |
| Therapist | | |  | | | | | | | | | |  | | | |  |
| Medical Provider | Specialist | | |  | | | | | | | | | |  | | | |  |
| Specialist | | |  | | | | | | | | | |  | | | |  |
| Specialist | | |  | | | | | | | | | |  | | | |  |
| **Attach Most Current Immunization Records** | | | | | | | | | | | | | | | | | | |
| **Complex Medical Needs** | | | | | | | CLASSIFICATION | | | | | | | |  | | | |
| Yes  No | | | | | If Yes, Level | | 1 | | 2 | | | 3 | 4 | |  | | | |
| **Diagnoses Acute/Chronic – Past Procedures – Physical Exams** | | | | | | | | | | | | | | | | | | |
| 1. | | | | | | | | | |  | Baseline Physical Findings: | | | | | | | |
|  | | | | | | | | | |  |  | | | | | | | |
| 2. | | | | | | | | | |  |  | | | | | | | |
|  | | | | | | | | | |  |  | | | | | | | |
| 3. | | | | | | | | | |  | Baseline Vital Signs: | | | | | | | |
|  | | | | | | | | | |  |  | | | | | | | |
| 4. | | | | | | | | | |  |  | | | | | | | |
|  | | | | | | | | | |  |  | | | | | | | |
| Synopsis: | | | | | | | | | |  | Baseline Neurological Status: | | | | | | | |
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| **Allergies Epi Pen:**  **Yes**  **No** | | | | |  |  | | | | | | |
| Medication/Foods to be Avoided: | | | | |  | Associated Adverse Reactions: | | | | | | |
| 1. | | | | |  |  | | | | | | |
| 2. | | | | |  |  | | | | | | |
| 3. | | | | |  |  | | | | | | |
| Procedures to be Avoided: | | | | |  | and Why: | | | | | | |
| 1. | | | | |  |  | | | | | | |
| 2. | | | | |  |  | | | | | | |
| 3. | | | | |  |  | | | | | | |
| **Common Presenting Problems/Findings with Specific Suggested Managements** | | | | | | | | | | | | |
| Problem: |  | Suggested Diagnostic Studies: | | | | | | |  | Treatment Considerations: | | |
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| **Medications (Current)** |  |  |  |  | | |  | Date Started: | | |  |  |
|  | Dose: |  | Prescriber: | | |  |  | Purpose: |
|  |  |  |  |  | | |  |  | | |  |  |
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| **Special Equipment/Dietary Needs** (glasses, hearing aids, nebulizer, diabetic supplies, formula type, etc.) | | | | | | | | | | | | |
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| **Comments on Child, Family, or Other Specific Medical Issues** | | | | | | | | | | | | |
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| Completed by: | Date: |