All About My Child

The Children’s Hospital of Philadelphia
Hope lives here.
Helping your *child* when he or she needs to leave home

Every child is special and different. You know your child better than anyone.

This booklet helps you share information about your child with his or her temporary caretakers. The details you write here will be a great help to both your child and the temporary caretakers while your child is living away from home.

*Thank you!*

This booklet is about (fill in the name of your child):

____________________________________________________________________________

Important Contacts for My Child

DHS/CYS Worker ________________________________________________________________

Agency Worker ________________________________________________________________

Community Resources ___________________________________________________________
Full name of your child

Nickname

Date of birth

Ethnicity/Culture

Primary language  Religion

Will your child need access to special religious programs?  Yes  No

If yes, please share some details here.

Special hobbies or interests

Family members

Mom

Dad

Brothers/sisters

Other family members (such as grandparents, aunts and uncles)

Are both parents involved in the care of your child?  Yes  No
Insurance and ID number

Name of primary care doctor

Phone number of primary care doctor

Medical conditions

Does your child have any medication allergies?  ○ Yes  ○ No
If yes, please list.

Your child’s medications. Please list dosage and intake instructions.

Are your child’s immunizations up to date?  ○ Yes  ○ No
Please list the last immunization(s) your child received.

Are there any specialty doctors involved in your child’s care? Please list names, specialties and phone numbers.
Has your child been hospitalized recently? If so, please list locations, reasons and dates.


Has your child had surgery recently?  ○ Yes  ○ No

Are there any follow-up appointments coming up? If so, please list locations and dates.


Are there any dentist appointments or eye appointments coming up? If so, please list locations and dates.


Does your child wear glasses?
 ○ Yes  ○ No

If yes, are the glasses with your child?
 ○ Yes  ○ No
Does your child have any food allergies (for example, to peanuts or milk)?  ○ Yes  ○ No

If yes, please list:

Food _____________________ Reaction ________________________________
Food _____________________ Reaction ________________________________
Food _____________________ Reaction ________________________________

List your child’s favorite foods. ______________________________________
__________________________________________________________________
__________________________________________________________________

Is your child on formula?  ○ Yes  ○ No

If yes, what kind? __________________________________________________

How often is your child fed formula? __________________________________

How many ounces of formula at each feeding? __________________________

Has your child started taking any foods?  ○ Yes  ○ No

If yes, what kind of food and how often? __________________________________
__________________________________________________________________
__________________________________________________________________

My child takes food by  ○ mouth  ○ G-tube  ○ GJ tube  ○ NG  ○ NJ  Size of tube ______

Please tell us any other information about your child’s diet and eating habits that you think would be helpful. ________________________________________________
__________________________________________________________________
__________________________________________________________________

Is your child eligible for WIC?  ○ Yes  ○ No
Name of school ____________________________________________________________

Address ________________________________________________________________

____________________________________ Telephone number ________________

Grade and teacher _______________________________________________________

Does your child have any special education services at school?  ○ Yes  ○ No

Please share any information about your child and school that you think would be helpful.

________________________________________________________________________

________________________________________________________________________

About My Child Mental Health Treatment

Please fill in the following if your child receives mental health treatment.

Diagnosis ________________________________________________________________

Provider ________________________________________________________________

Medications _____________________________________________________________

________________________________________________________________________

Does your child have any mental health appointments coming up?  ○ Yes  ○ No

Date ______________ Location _____________________________________________

Reason for appointment _________________________________________________
Thank you for taking the time to fill out this booklet. This information will help the temporary caretakers and your child.

Keep the connection.

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youtube.com/ChildrensHospPhila
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Safe Place: Center for Child Protection and Health

The Children’s Hospital of Philadelphia
Hope lives here.

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1-800 TRY CHOP  www.chop.edu

Founded in 1855, The Children's Hospital of Philadelphia is the birthplace of pediatric medicine in America. Throughout its history, a passionate spirit of innovation has driven this renowned institution to pursue scientific discovery, establish the highest standards of patient care, train future leaders in pediatrics, and advocate for children's health. A haven of hope for children and families worldwide, CHOP is a nonprofit charitable organization that relies on the generous support of its donors to continue to set the global standard for pediatric care.