

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.

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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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

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