



<b>CHILD'S INFORMATION</b>		
CHILD'S NAME:		CHILD'S DATE OF BIRTH:
ADDRESS:	AGE:	MALE/FEMALE
CITY/STATE/ZIP:	COUNTY:	
<b>FAMILY INFORMATION</b>		
<b>PARENT 1/GUARDIAN'S NAME:</b>		DATE OF BIRTH:
EMAIL:		EMPLOYER:
HOME PHONE NUMBER:		
CELL PHONE NUMBER:		
WORK PHONE NUMBER:		
<b>PARENT 2/GUARDIAN'S NAME:</b>		DATE OF BIRTH:
EMAIL:		EMPLOYER:
HOME PHONE NUMBER:		
CELL PHONE NUMBER:		
WORK PHONE NUMBER:		
If address is different, please include here:		
<b>CHILD LIVES WITH:</b>		<b>CHILD'S RACE:</b>
<input type="checkbox"/> BOTH PARENTS	<input type="checkbox"/> FOSTER PARENTS	<input type="checkbox"/> CAUCASIAN
<input type="checkbox"/> ONE PARENT	<input type="checkbox"/> ADOPTIVE PARENTS	<input type="checkbox"/> HISPANIC
<input type="checkbox"/> PARENT AND STEP-PARENT	<input type="checkbox"/> OTHER ADULT OR SIBLINGS	<input type="checkbox"/> ASIAN OR PACIFIC ISLANDER
		<input type="checkbox"/> AFRICAN-AMERICAN
		<input type="checkbox"/> NATIVE AMERICAN
		<input type="checkbox"/> OTHER: _____
IS THERE A LANGUAGE OTHER THAN ENGLISH SPOKEN IN THE HOME? _____		
DOES THE CHILD SPEAK THIS LANGUAGE? <b>YES OR NO</b>		DO THEY UNDERSTAND IT? <b>YES OR NO</b>
WHO SPEAKS IT?		
<b>MEDICAL HISTORY</b>		
PEDIATRICIAN'S NAME:		OFFICE NUMBER:
WHERE WAS THE CHILD BORN (HOSPITAL, CITY, STATE):		
PRENATAL CARE: Y/N		
COMPLICATIONS DURING PREGNANCY: Y/N		(IF YES, PLEASE DESCRIBE)
WEEKS OF PREGNANCY:		CHILD'S BIRTH WEIGHT
TYPE OF DELIVERY: <input type="checkbox"/> VAGINAL <input type="checkbox"/> C-SECTION: WHY?		
WERE FORCEPS USED DURING DELIVERY: Y/N		
PROBLEMS DURING DELIVERY:		DAYS CHILD STAYED IN HOSPITAL:
PROBLEMS AFTER THE DELIVERY FOR MOTHER OF CHILD: Y/N (IF YES, PLEASE DESCRIBE)		
NICU, COMPLICATIONS, OR OTHER CONCERNS PRIOR TO DISCHARGE: Y/N (IF YES, PLEASE DESCRIBE)		
HAS THE CHILD EVER BEEN HOSPITALIZED SINCE THEIR DISCHARGE HOME FROM THE HOSPITAL: Y/N		
DOES THE CHILD TAKE ANY REGULAR MEDICATIONS: Y/N (PLEASE LIST)		