BHSF Form MS/C
Rev. 04-2020
Prior Issue Obsolete

CHILD'S MEDICAL & SOCIAL INFORMATION

(to be completed by parent/guardian/care-giver)

INSTRUCTIONS	► Please fill out completely. **Please Print**. ► Failure to do so may delay the decision.

IDENTIFYING INFORMATION

1. Child's Name: _____ Today's Date: _____
   ❑ Male ❑ Female Age: ____ Height/Weight: _____ Parish of Residence: _____
   Date of Birth: __ __ / __ __ / __ __ __ __ Social Security Number: __ __ __ - __ __ - __ __ __ __

2. Name of person providing information: _____
   Relationship to child: _____

3. Describe the child's condition and how it affects his or her daily activities: _____
   _____
   _____
   _____

4. At what age did the condition begin? _____

5. At what age was the condition first treated? _____

SCHOOL INFORMATION

6. What grade is the child currently attending? _____ Teacher's Name: _____

7. Please list school/preschool information below for the last two years. If more space is required, add additional pages. Attach Individual Education Plan (IEP) or other Pupil Appraisal reports, if any.

Current School Name		Previous School Name	
Address		Address	
City, State		City, State	
Zip Code		Zip Code	
Phone Number	( )	Phone Number	( )
Dates attended		Dates attended	
Any special education services received? ❑ Yes ❑ No	If **yes**, reason for special education:	Any special education services received? ❑ Yes ❑ No	If **yes**, reason for special education:

8. Does child have any behavioral problems in school? ❑ Yes ❑ No

If **yes**, please describe: _____

_____

Have behavioral problems resulted in any in-school or out-of-school suspensions? ❑ Yes ❑ No

If **yes**, please explain: _____

_____

9. If child is school-age but is **not** in school, please explain why he or she is not in school: _____

_____

_____

10. Has child been tested for learning or behavioral problems at school? ❑ Yes ❑ No

If **yes**, please list type of tests, and where and when testing was done: _____

_____

_____

ACTIVITIES

11. How does the child spend free time? List hobbies (reading, collecting, computer, etc.) and/or activities (sports, dance, school activities, scouting, clubs, etc.) and how often he/she participates:

_____

_____

_____

12. Have there been any changes in the child's activities or behavior since his/her condition began?

❑ Yes ❑ No If **yes**, please explain: _____

_____

_____

13. Does the child help with household chores? ❑ Yes ❑ No If **yes**, what are the chores (make bed, feed pets, clean room, yard work, etc.) and how often are they done? _____

_____

_____

How much assistance does the child need to complete chores? _____

14. How does the child behave with adults (parents, teachers, neighbors)? Please give examples:

_____

_____

15. How does the child relate with peers (friends, other family members)? Please give examples:

_____

_____

16. Is the child able to care for himself/herself in an age appropriate way? ❑ Yes ❑ No

If **yes**, please give examples: _____

_____

_____

_____

MEDICAL AND HEALTHCARE INFORMATION

17. List all medications that the child currently takes for his/her condition and who prescribes it:

Name of medication	Dosage and how often taken	Who prescribed?	Date of last visit with this provider

18. How does the medication affect the child? _____

_____

_____

19. During the last **24 months**, has the child received any testing or special examinations (hearing or vision tests, IQ testing, blood tests, breathing tests, X-rays, etc.)? Please list these below and include HeadStart, Early Intervention Services, Mental Health/Intellectual Disability Centers, etc.:

Name of Doctor/ Hospital/Clinic/Agency including specialists	Address, Zip Code, and Phone Number	Date of test or evaluation	Type of test or evaluation

20. Does the child's condition cause pain or discomfort? ❑ Yes ❑ No

If **yes**, how does this affect his/her daily activities? _____

_____

_____

21. During the last **12 months**, where has the child received medical/psychological treatment?
❑ Mental Health Clinic ❑ Private Physician/Therapist ❑ Clinic ❑ Hospital ❑ Other Source
Please list below:

Name of Doctor/ Hospital/Clinic/Agency including specialists	Address, Zip Code, and Phone Number	Dates treated	Reason for treatment

OTHER INFORMATION

22. Has this child applied for Supplemental Security Income (SSI) benefits? ❑ Yes ❑ No
If **yes**, when? _____
What is the status of the application? ❑ Approved ❑ Pending ❑ Appealed ❑ Denied ❑ Terminated
If **denied** or **terminated**, when? _____
Why? _____
_____
_____

23. Tell us any other information that you think we need to know about this child: _____
_____
_____
_____
_____
_____
_____
_____

Name of person completing form: _____

Date: _____ Phone Number: _____