CHILDREN'S VILLAGE

OAKLAND COUNTY EXECUTIVE DAVID COULTER

Heather Calcaterra, Manager
(248) 858-1151 | cvillage@oakgov.com

MEDICAL HISTORY

Resident's Name: ______________________ D.O.B.: __________

Age _____ Male: _____ Female: _____ Resident's Social Security #: __________

Mother: ______________________ Phone: __________

Address: ______________________

Father: ______________________ Phone: __________

Address: ______________________

Legal Guardian(s) Information: Name: ______________________

Legal Guardian's Relationship to Child: ______________________

Address: ______________________ Phone: __________

In case of emergency notify: Name: ______________________

Relationship to Child: ______________________ Phone: __________

Address: ______________________

Health Insurance Information: Health Insurance Company ______________________

Contract / ID Number: ______________________ Group Number: __________

Prescription Coverage Information: ______________________

Subscriber's Name on Insurance Card: ______________________

Medicaid ID Number: ______________________ Subscriber: __________

Children's Special Health Care Services: No ☐ Yes ☐ If Yes, CSHCS Number: __________

Please check any of the below that your child has had:

Drug Overdose	____	Substance Abuse	____	Nervous Disorder	____	Suicide Gestures	____
Red or Hard Measles	____	Shortness of Breath	____	Frequent Headaches	____	Seizures	____
German or 3 Day Measles	____	Heart Trouble	____	Frequent Diarrhea	____	Epilepsy	____
Scarlet Fever	____	Rheumatic Fever	____	Frequent Constipation	____	Hearing Loss	____
Whooping Cough	____	Strep Infection	____	Pregnancy	____	High Blood Pressure	____
Mumps	____	Bone / Joint Problem	____	History of Heart Murmur	____	Menstrual Problems	____
Chicken Pox	____	Hepatitis	____	Meningitis	____	STD's	____
Diabetes	____	Eye Problems	____	Bed Wetting	____	AIDS / HIV	____

Provide details of any conditions listed above or other conditions not listed: ______________________

____

____

Is child able to take part in normal sports, school activities, gym class? Yes ☐ No ☐ If No, please explain below:

____

Has child even been injured, hospitalized or had operations? No ☐ Yes ☐ If Yes, please explain below:

Has child been under a physician's care in the last 12 months? No ☐ Yes ☐ If Yes, please explain below:

Physician's Name ______________________ Phone Number: ______________________

Does your child wear glasses? No ☐ Yes ☐ If Yes, are the glasses with the child? ______________________

Does your child wear hearing aids? No ☐ Yes ☐ If Yes are the hearing aids with the child? ______________________

Does child have any allergies? No ☐ Yes ☐ If Yes, please list allergies: ______________________

If any food allergies, please describe what happens: ______________________

Does child have special diet needs? No ☐ Yes ☐ If Yes, please state dietary needs: ______________________

Is child currently on medication? No ☐ Yes ☐ ***If Yes, please list the medication and dosage below***:

Have you brought in medication? No ☐ Yes ☐ ***Please bring in all current medications (Date within 30 days)***

MEDICATION	**DOSAGE**

Additional Information / Comments: ______________________

Signature of Parent / Legal Guardian

Date