ATTENTION: *This is an electronic form in FamLink.* *ersion must only be used when FamLink is not available.*

STATE OF WASHINGTON
DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)

Health / Mental Health and Education Summary

Date:

To:

From: Phone: Email:

Attached, please find a comprehensive health report for the following child:

NAME OF CHILD _____ DATE OF BIRTH _____

If this child is no longer living with you, please destroy this document as you would any confidential information or return it to your social worker.

The information contained in this report is confidential, however, it should be shared with the child's physicians, dentists and therapists to assure appropriate services are provided.

The information included in this report is limited by the availability of health and education records. This report is supplemental to any previous health reports created. All medications listed in this report should be discussed with the child's primary health care provider. **Please take this report with you to all health/mental health appointments.**

If I may be is assistance, or if you have any questions, please do not hesitate to call me. Also, please contact me at any time with new health and education concerns you might have for this child.

Thank you for your time.

NOTE: **The information displayed is not a complete or current reflection of the child's health care status. Please consult with the child's medical providers before using this information to guide physical or behavioral health care for a child.** All information contained in this report is confidential, and disclosed under the limitations of RCW 13.50.100. This disclosure does not constitute a waiver of any confidentiality privilege attached to the records by operation of any state or federal law or regulation. The recipient of these records must comply with the laws governing confidentiality and must protect the records from unauthorized disclosure. The recipient should share this information with the child's health care provider

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DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)

Health / Mental Health and Education Summary

Child Information

CHILD'S NAME			GENDER ☐ Male ☐	DATE
DATE OF BIRTH	AGE	STATE STUDENT ID	PERSON ID	

Health / Mental Health Conditions

DATE IDENTIFIED	END DATE	MEDICALLY CONFIRMED	CURRENT / HISTORICAL
CONDITION		SOURCE	
PROVIDER NAME		PHONE NUMBER	
COMMENTS			

Exams / Evaluations

EXAM DATE	PROVIDER NAME	PHONE NUMBER
TYPE OF EXAM		
EXAMS / PLANS / RECOMMENDATIONS		

Allergies

DATE IDENTIFIED	END DATE	MEDICALLY CONFIRMED	CURRENT / HISTORICAL
ALLERGIC TO		ALLERGIC REACTION	
ALLERGIC REACTION PLAN			

Medications / Equipment

PRESCRIPTION DATE	MEDICATION OR EQUIPMENT NAME	DOSAGE
PROVIDER NAME		PHONE NUMBER
REMARKS		

Hospitalizations

ADMIT DATE	DISCHARGE DATE	TYPE	ER / INPATIENT

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HOSPITAL NAME	PHONE NUMBER	PROVIDER NAME

ADMIT / DISCHARGE INFORMATION

Mental Health Treatment

DATE	TREATMENT PLAN

PROVIDER NAME	PHONE NUMBER

COMMENTS

Appointments

APPOINTMENT DATE	APPOINTMENT TIME	TYPE

PROVIDER NAME	PHONE NUMBER

Birth Information

WEIGHT	HEIGHT	TOX SCREEN	GESTATIONAL AGE	APGAR

EXAMS / RECOMMENDATIONS

HOSPITAL NAME	PHONE NUMBER	PROVIDER NAME

Immunizations

DATE	IMMUNIZATION	SOURCE

School Information

ENROLLED DATE	END DATE	PRIMARY SCHOOL

SCHOOL NAME	DISTRICT	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

SCHOOL YEAR / TERM	CURRENT GRADE	CURRENT PERFORMANCE

Special Education

SPECIAL EDUCATION SERVICES NEEDED OR PROVIDED ☐ Yes ☐ No	SUPPORTING DETAIL

TYPE ☐ IEP ☐ 504 ☐ IFSP	START DATE	REVIEW DATE	END DATE

COMMENTS

Referrals

REFERRAL DATE	REFERRAL TO:

COMMENTS