CHILD HEALTH CARE ASSOCIATES ANNUAL UPDATE (Rev 2020)

Child(ren)'s Name________________________________ Date of Birth____________ Today's Date_________
Name of person filling out this form ________________________Relationship to Child___________________
Primary Phone #: ________________________ Cell # for Text Message Reminder: _____________________

Parent #1 Name_______________________________ Date of Birth____________
Address: ______________________________________ Employer_________________________
______________________________________ Occupation_______________________
Cell Phone # _______________________________

Parent #2 Name_______________________________ Date of Birth____________
Address (if different from above): ______________________________ Employer_______________________
______________________________ Occupation______________________
Cell Phone # _____________________________
Pharmacy if you need a prescription today___________________________
Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Other______________ ☐ Declined to specify
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Declined to specify ☐ Other______________

Parents are: (circle one) MARRIED UNMARRIED DIVORCED SEPARATED OTHER____________

If parents are living in separate households, who has primary custody? _______________________

Emergency Contact Name: __________________________ Phone#________________________

Allergies: ____

Chronic Medical Conditions: ____
____

Surgeries/Hospitalizations within the last year: ____
____

Injuries/accidents within the last year: ____
____

Any new family medical history we should be aware of? ____
____

Guns in the home? (circle answer)	YES	NO	If Yes:	LOCKED	UNLOCKED
Is your child exposed to smoke in the home?	YES	NO			
Are there smoke alarms in the home?	YES	NO			

TB Screen: (circle answer)

Has a family member or contact had tuberculosis disease?	YES	NO
Has a family member had a positive tuberculin skin test result?	YES	NO
Was your child born in a high-risk country (Countries other than US, Canada, Australia, New Zealand, or Western European countries?	YES	NO
Has your child traveled (had contact with resident populations) to a high-risk country for more than one week?	YES	NO