

## CHILD HEALTH CARE ASSOCIATES ANNUAL UPDATE

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 \_\_\_\_\_

Parents are: (circle one)    MARRIED    UNMARRIED    DIVORCED    SEPARATED    OTHER \_\_\_\_\_

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

Emergency Contact Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Current Medications: \_\_\_\_\_

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