



AdoptionLinks

A program of Jewish Family Service of Greater Harrisburg Inc.

HEALTH FORM FOR CHILDREN

Name _____ DOB _____ Sex _____
 Date of last physical or doctor visit _____ Reason: _____
 Name of Pediatrician _____ Telephone number _____
 Child's Height _____ Child's Current Weight _____
 Date of last dental check up _____
 Name of Dentist _____ Telephone Number _____
 Name of Optometrist _____ Telephone Number _____

Any chronic or recurring illness _____ Treatment/medication _____

Any hospitalizations or operations _____ Dates _____

Any mental health diagnosis or behavioral difficulties _____
 Psychotropic Medications: _____
 Current or previous therapy: _____

Any Developmental concerns and/or therapist (speech, occupational, early intervention)
 Please list any services and provider: _____

Medical history of child: (Check and give dates when possible)
 Chicken pox _____ Mumps _____
 Measles _____ Rubella _____
 Pertussis _____ Pneumonia _____
 Asthma _____ Allergies _____

**Please attach a copy of the child's current immunization record or written explanation for no immunizations*

I/We give permission to Jewish Family Service to obtain additional information from any of the listed medical providers, as needed to complete adoption related documents. This release is valid for three months from date of signature below.

Parent/Guardian Signatures

Date: