## ACTIVE PROBLEMS, Cont'd

| Problem | Date Noted | Management/Medications | Next Due | Clinic Telephone Number |
|---|---|---|---|---|
| | | | | |

Resource ID#: 20

Child Personal Health Information (portable record)

## IMPORTANT

**TO PATIENT:**

- Keep this record with you.
- Go to the nearest health care center for medical services.
- Show it when child makes visit for any health care.
- Make sure your child's immunizations (Shots) are up to date and entered on this card.
- KEEP YOUR CHILD PROTECTED! Ask when your child needs the next immunization.

## *IMPORTANTE*

***AL PACIENTE:***

- *Guarde esta tarjeta con Usted siempre.*
- *Vaya a la clínica de salud más cercana para servicios médicos.*
- *Presente esta tarjeta cuando vea al doctor o vaya a una clínica.*
- *Asegúrese que las vacunas de sus niños estén al corriente y sean indicadas en esta tarjeta.*
- *PROTEJA A SUS NIÑOS! Pregunte cuando su niño necesita la siguiente vacuna.*

## IMPORTANT

**TO PROVIDER:**

- Make sure All medical information is updated and entered on this card.
- For additional medical information call the referring health provider.
- Call the NMRP TOLL FREE NUMBER for Immunization/Medical Information.

U.S. 1-800-531-5120

REV. 3/88

(Courtesy of the National Migrant Referral Project, Austin, Texas)

# CHILD PERSONAL HEALTH INFORMATION

## *Para Niños Información De Salud Personal*

Name: _____
*Nombre* *Last* *First* *M.I.*

Birthdate: _____
*Fecha De Nacimiento* *Month* *Day* *Year*

Sex: ☐ Male ☐ Female

Home Address: _____
*Domicilio*
_____

Father's Name: _____
*Nombre del Padre*

Mother's Name: _____
*Nombre de la Madre*

Other Relative: _____
*Otro Familiar*
_____

### REFERRING HEALTH PROVIDER
***Clínica, Médico, Centro de Salud***

Name of Clinic: _____
_____

Address: _____
_____
*City* *State* *Zip*

Telephone #: _____
*A.C.*

Chart #: _____

Name _____

IMMUNIZATIONS: If not given by referring health provider, then also enter into Active Problems list (e.g., well child visit) and include your clinic's telephone number.

| Type | Date | Date | Date | Date | Date | Date |
|---|---|---|---|---|---|---|
| DPT | | | | | | |
| TOPV | | | | | | |
| DPT & TOPV BOOSTER | | | | | | |
| Td BOOSTER | | | | | | |
| T | | | | | | |
| MEASLES: Date: | | | MUMPS: Date: | | RUBELLA: Date: | |

GENERAL HEALTH INFORMATION: Significant abnormal findings should appear in Problem List, Inactive or Active.

| **ITEM** | Dates Last Done | | |
|---|---|---|---|
| Hgb/Hct | | | |
| UA | | | |
| Tbn Test | | | |
| Vision Test | | | |
| Hearing Test | | | |
| Sickle Test | | | |
| STS | | | |
| Dental Screen | | | |
| Topical Flouride | | | |
| Lead Screen | | | |
| WIC Services | | | |
| Other: | | | |

| **ALLERGIES** - Sensitivities | |
|---|---|
| Drugs: | Date |
| | |
| | |
| | |
| Other: | |
| | |
| | |

**SIGNIFICANT INACTIVE PROBLEMS/HOSPITALIZATIONS** - Date

| |
|---|
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## ACTIVE PROBLEMS

| Problem | Date Noted | Management/Medications | Next Due | Clinic Tel. Number |
|---|---|---|---|---|
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| | | | | |

Name _____

IMMUNIZATIONS: If Not Given By Main Provider, then also enter into Problem List (e.g. well child visit) and include provider's contact phone number.

| TYPE | SUGGESTED AGE | DATE | SUGGESTED AGE | DATE | SUGGESTED AGE | DATE |
|---|---|---|---|---|---|---|
| DPT | 2 mo. | | 4 mo. | | 6 mo. | |
| TOPV | 2 mo. | | 4 mo. | | 6 mo. | |
| DPT & TOPV Booster | 18 mo. | | 4-6 years | | | |
| Td Booster | 14-16 years | | Every 10 years | | | |
| T | | | | | | |
| Measles: 15 mo. Date: | | Mumps: 15 mo. Date: | | Rubella: 15 mo. Date: | | |

GENERAL HEALTH INFORMATION: Significant abnormal findings should appear in Problem List, Inactive or Active.

| ITEM | Date Last Done | | | | |
|---|---|---|---|---|---|
| Hgb/Hct | | | | | |
| UA | | | | | |
| Tbn Test | | | | | |
| Vision Test | | | | | |
| Hearing Test | | | | | |
| Sickle Test | | | | | |
| STS | | | | | |
| Dental Screen | | | | | |
| Topical Flouride | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

ALLERGIES — Sensitivities

| Drugs: | Date |
|---|---|
| | |
| | |
| Other: | |
| | |
| | |

| SIGNIFICANT INACTIVE PROBLEMS/ HOSPITALIZATIONS | Date |
|---|---|
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## ACTIVE PROBLEMS

| Problem | Date Noted | Management/Medications | Next Due | Provider Contact Phone #: |
|---|---|---|---|---|
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