CCL 055
Rev 7/12

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
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HEALTH CHECKLIST
FOR EMERGENCY/TEMPORARY CARE

Name _____ Date_____
Facility _____ Interviewer _____

1. Are you having any health problems at the present time? Yes_____ No_____
   Describe_____

2. Have you had any of the following problems in the past 24 hours?

	YES	NO		YES	NO		YES	NO
Sore Throat			Nausea/Vomiting			Diarrhea		
Earache			Headache			Abdominal Pain		
Swollen Glands			Skin Rash			Kidney/Urinary		
Fever/Chills			Drug Reaction					

3. Do you have any medical problems such as:

	YES	NO		YES	NO		YES	NO
Heart Problems			Diabetes			Seizures/Convulsions		
Physical Disability			Asthma			Other		

   If other please explain_____

4. Do you think you have an infectious/communicable disease such as:

	YES	NO		YES	NO
Hepatitis/Liver Problem			Sexually Transmitted Disease (STD/VD)		
Mononucleosis			Other		

   Please explain_____

5. Why do you think this?_____

6. Do you think you have been exposed to any communicable disease in the past 2-3 weeks? Yes _____ No_____
   Why do you think this?
   _____

7. Are you taking any kind of medication or shots? Yes _____ No _____
   If Yes, What kind? What for? _____
   Name/Address of physician who ordered it _____

8. Are you allergic to anything like aspirin, foods, medicine, etc?
   Specify _____
   What happens? _____

9. For girls only: Do you take birth control pills? Yes _____ No _____
   If yes, when did you take your last pill? _____

Date of last menstrual period: _____

10. Have you ever tried to hurt yourself or others, or thought about or attempted to commit suicide? Yes_____ No_____
    If yes, when and how? _____

11. Have you used any street drugs? Yes_____ No_____
    If yes, what kind and when? _____

12. Are you currently sexually active? Yes _____ No _____
    Do you use any method of birth control or any protection? _____

13. Name/address of your family doctor _____
    Approximate date of last visit: _____

Record any observations such as personal appearance, mannerisms, ability to answer questions, indications that the youth may be using drugs, is suicidal, etc. Sign each note with professional signature.

Date	Progress Notes

14. Medical care is needed? Yes _____ No_____
Medical care obtained (date): _____ (time)_____

_____

Staff completing form _____ Date _____