Kackaamin
FAMILY DEVELOPMENT CENTRE

Child and Youth Medical Assessment

Section 1 of 2 – *Consent to release Client Medical Information*

I (parent), ________________________________, hereby request and permit my physician to release any medical facts and assessments about my child to Kackaamin Family Development Centre and the referring agency listed above.

Child Patient's Name: ___________________________

Signature of Parent: ____________________________ **Date:** _________________

N.B. for the attending Physician:

Some Child Clients may be required to have complete physical examination prior to admission. They should not require any acute medical care at the time of admission to Kackaamin. All communicable diseases should be in remission and properly medicated.

KFDC requires the above client to be medically assessed as a potential participant in our six week residential substance misuse treatment program. The KFDC program is designed to help people acknowledge that substance misuse has interfered with their lives. Please assess if they are physically and mentally ready to participate in a program of that offers counselling and educational workshops.

Section 2 of 2 – Pre admission Medical Information

(To be completed by the Parent/Guardian)

Patient's Name: ___________________________ Date of Birth: _____________________

Care Card Number: ________________________ Status Number: ____________________

Physical Exam – *medical information*

1. Known Allergies: ☐ Yes ☐ No

   If "yes", what is the Patient allergic to? ____

   N.B. the patient must bring their own epipen if they are apitoxin allergic. Please prescribe one if needed.

Client's Name: ________________________

2. Please check all issues that apply.

☐ E.E.N.T ☐ Chronic Cough ☐ F.A.S.D. ☐ Cancer ☐ Pregnant ☐ Arthritis ☐ Asthma

☐ G.I. ☐ Seizures ☐ Freq U.T.I. ☐ Neurological disorder

☐ Epilepsy ☐ Date of last seizure ________________

☐ HIV / AIDS

☐ S.T.I. ☐ Type ___________________________

Hepatitis *(please circle any that apply)* A B C

Sensory Impairment *(please circle any that apply)* vision hearing olfactory

Does the patient have any other type of special need (i.e. learning disability, difficulties with reading, writing?) ☐ Yes ☐ No

Please describe: ____

Tuberculosis ~ TB *(please circle any that apply)* Active Dormant

(The patient must have had a T.B. Test in the last 12 months) Date __________________

N.B. If the TB skin test is positive and the results measure larger than 10mm, a subsequent TB chest X-ray must be performed.

3. Does the patient have a heart condition? *(Please name the condition)* __________________

   ____

   What is the patient's Blood Pressure? ____

4. Does the patient have an infestation of any kind (i.e. lice, scabies)? ____________________

5. Diabetes: ☐ Yes ☐ No

   Does patient manage blood glucose levels with ☐ Pills ☐ Insulin Injection?

   What are the target blood glucose levels? ____

6. Has the patient ever been diagnosed with a Mental Health Problem? ☐ Yes ☐ No

   If yes when: _____________________ (date) Specify the diagnosis __________________

   Name of Psychiatrist/Psychologist: ____

   Phone: __________________________

Client's Name: _________________________

7. Does the patient have allergies to any medication? ______________________________

8. Are you aware of current or recent medical problems which may require follow-up while the patient is in treatment at KFDC? ☐ Yes ☐ No

   ____

   ____

9. Does the patient have a dual diagnosis or co-morbidity? ☐ Yes ☐ No

   If "Yes" please list the illnesses, date of diagnosis, medication prescribed and any information that you deem pertinent.

   ____

   ____

10. Are the Child or Youth's Immunizations currently up to date? ☐ Yes ☐ No

    Explain: ____

N.B. Please attach a copy of the child or youth's current Immunization record.
(This section to be completed by the Physician / RN / CHN in the event that parent/guardian are not able to.)

Name: ______________________________

Address: ______________________________

City: ______________________________

Postal Code: ______________________________

Telephone: ______________________________

Fax: ______________________________

OFFICE STAMP

______________________________ ______________
(Physician / RN / CHN's Signature) *(Date)*

Client's Name: ______________________________