Clear

EMERGENCY INTAKE

Date and Time:_____ County:_____

Child's Name:_____ Date of Birth:_____

Child's Physician Contact Information:

Physician's Name	Physician's Phone Number
Physician's Address	

Are siblings also in foster care? ☐ Yes ☐ No

If yes, siblings' names and ages:_____

Parents'/Caregivers' Names:_____

Reasons for Removal:

☐ Suspected Physical Abuse ☐ Suspected Neglect ☐ Father Incarcerated ☐ Mother Incarcerated

☐ Suspected Sexual Abuse ☐ Other (specify):_____

Any known allergies: ☐ Yes ☐ No

If yes, list allergies:_____

Any known physical or emotional problems: ☐ Yes ☐ No If yes, list problems:

Any special dietary needs/formulas: ☐ Yes ☐ No If yes, list needs:

I (print name of parent or legal guardian) _____ certify that my child (print child's full name) _____ is currently prescribed and taking the listed medications and by my signature I am giving authorization to the Department of Children and Families to continue to provide the listed medications and continue any listed behavioral health services.

Signature of Parent:_____ **Date:**_____

Medications	Reason for taking medication	Dosage	Length of Time on Medication	Giving to Shelter/ Foster Parent
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Medical Equipment/Information Accompanying Child: ☐ Eyeglasses ☐ Medication ☐ Medical Equipment

☐ Immunization Records ☐ Newborn Discharge Summary

Where is the child being taken: ☐ Temporary shelter ☐ Relative of family ☐ Temporary foster home

☐ Friend of family ☐ Other (specify):_____

Contact Name:_____ Phone Number:_____

Address:_____

Notes:

Name/Title of
person completing form:_____ Phone #:_____