## Placement Checklist and Medical Authorization

THIS CHECKLIST IS REQUIRED FOR USE WHEN A CHILD IS PLACED. PLEASE REMEMBER THAT, IN AN EMERGENCY, DCF MAY HAVE LITTLE INFORMATION ABOUT THE CHILD AND HIS OR HER SITUATION/NEEDS. ALSO PLEASE MAKE SURE THERE IS A COMPLETED AUTHORIZATION FOR TREATMENT ATTACHED TO THIS FORM.

Child's name: _____

Date of Birth: _____ SSN: _____

Parent's names: _____

Social Worker: _____ Phone: _____

Supervisor: _____ District: _____

If child has been physically or sexually abused, briefly state by whom and the nature of the abuse:

_____

_____

Doctor(s): _____

Dentist: _____

Health Insurance: ☐ Free-for-Service Medicaid ☐ PC Plus Medicaid

☐ Private Insurance: _____

Medical Concerns/conditions: _____

Current medications, including dosage: _____

_____

☐ Authorization for Medical Treatment Completed

Plan for Contact with Family and others. List any concerns the resource family should be aware of: _____

_____

_____

If there is any history of threatening behavior towards resource families by the child or family, describe (when, how often, what kind): _____

_____

Grade: ____ ☐ IEP ☐ 504 plan ☐ Individual aide Last School: _____

Reimbursement rate: _____ Usual Expenses: _____

| **Behavior/ Issues** | Past 6 Mos. | Before 6 Mos. | No Information | | Past 6 Mos. | Before 6 Mos. | No Information |
|---|---|---|---|---|---|---|---|
| Sexually active | | | | Sets Fires | | | |
| Sexually reactive or aggressive | | | | Temper tantrums | | | |
| Destructive of property | | | | Substance use/abuse | | | |
| Steals | | | | Eating disturbances | | | |
| Problems with the law | | | | Sleeping disturbances | | | |
| Confused/strange ideas | | | | Bladder/Bowel problems | | | |
| Injures self | | | | Aggressive toward people/animals | | | |
| Suicidal thoughts or behaviors | | | | Difficulties at school | | | |

Date of next hearing: _____ Date of next meeting with social worker: _____

Social Worker Signature: _____ Date: _____

Foster Parent Signature: _____ Date: _____