

Case Number: \_\_\_\_\_

**Supplemental Health Assessment  
Child and Youth Services  
West Point, New York**

---

**Part A: *To be completed by parent/guardian:***

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SPONSOR'S NAME: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: (H): \_\_\_\_\_ (W): \_\_\_\_\_

PRESENTING CONCERN: \_\_\_\_\_

CYS PLACEMENT: Full day CDC PD Care Hourly FCC SAS YS Summer Camp

---

**Part B: *To be completed by child's licensed health care provider:***

1. Current medical concerns/diagnosis: \_\_\_\_\_

\_\_\_\_\_

2. What should a childcare provider expect as a result of the above listed medical concerns: \_\_\_\_\_

\_\_\_\_\_

3. Allergies (Medications/Foods/Insects): NO YES: \_\_\_\_\_

\_\_\_\_\_

4. Special dietary requirements: NO YES: \_\_\_\_\_

\_\_\_\_\_

5. List all current medications: \_\_\_\_\_

\_\_\_\_\_

6. List appliances/environmental adaptations required to accommodate this child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Continuation of Supplemental Health Assessment**

7. Additional instructions for caregiver: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I request that my patient receive the following medication(s) from the Child & Youth Services staff:*

Medication	Dose	Frequency	Route	Rx Duration

7. Possible medication side effects/adverse reactions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician/Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Phone: \_\_\_\_\_