Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

Medical Update Form

Franklin County Public Health
BCMH Program

TODAY'S DATE _____

1. Complete BOTH sides of this form to keep your child's information up-to-date.
2. Sign the **"Release of Information."**
3. Fax this form to 614-525-6673 or email to bcmh@franklincountyohio.gov or mail in the envelope provided.
4. **THIS IS NOT A BCMH RENEWEL FORM;** this information helps your Public Health Nurse help you and your child.

Child's Information and Your Information

Child's First Name		M.I.	Child's Last Name
Child's Date of Birth:	☐ Male ☐ Female	Your relationship to Child:	
Whom Does Child Live With? ☐ Mom ☐ Dad ☐ Both Parents ☐ Guardian ☐ Other (Relationship)			
Child's Address:			
First & Last Name of Parent/Legal Guardian 1: Address: City: Zipcode:		First & Last Name of Parent/Legal Guardian 2: Address: City: Zipcode:	
Contact Phone Number(s) for Parent/Guardian 1: ☐ Home ☐ Mobile ☐ Work Check Box Above For Best Day Phone Number Where To Reach You At		Contact Phone Number(s) for Parent/Guardian 1: ☐ Home ☐ Mobile ☐ Work Check Box Above For Best Day Phone Number Where To Reach You At	
Email Address for Parent/Legal Guardian 1		Email Address for Parent/Legal Guardian 2	
Primary Language Spoken at Home (if other than English)		Do You Need an Interpreter? ☐ Yes ☐ No	

Release of Information

I hereby authorize Franklin County Public Health to release and receive medical records and confidential information; any and all financial information and third-party payers (and their agents and employees) for the purpose of providing or facilitating the delivery of or arranging for services to the client; to administer the program for medically handicapped children or other programs funded with monies received from the "Maternal and Child Health Block Grant"; to coordinate the provisions of services under the programs with other state agencies, city and general health districts; and coordinate payment of providers. **This Release Authorization is effective from the date of my signature and will remain in effect until such time as I expressly revoke it in writing.** I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law.

_____
Signature of Parent, Guardian, Client (if 18 years or older)

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General Health Information

Are your child's shots current? ☐ Yes ☐ No	Are your family's shots current? ☐ Yes ☐ No
Does your child have a family doctor? ☐ Yes ☐ No	Does your child have a dentist? ☐ Yes ☐ No
Doctor's Name:	Dentist's Name:
Address:	Address:
Phone:	Phone:
Date Last Seen?	Date Last Seen?
Does your child see any specialists? ☐ Yes ☐ No	Who is the Managing Physician?

1. Specialist's First and Last Name, Practice/Location and Phone Number	Date Last Seen?
Name:	
Address:	
Phone:	
2. Specialist's First and Last Name, Practice/Location and Phone Number	Date Last Seen?
Name:	
Address:	
Phone:	
3. Specialist's First and Last Name, Practice/Location and Phone Number	Date Last Seen?
Name:	
Address:	
Phone:	
Does your family have an emergency medical, fire, disaster plan in place? ☐ Yes ☐ No	
Would a phone call or home visit by you Nurse be helpful to you and your child at this time? ☐ Yes ☐ No	

Do you have Nutritional Concerns about Your Child's…?

Weight? ☐ Yes ☐ No	Chewing and/or swallowing foods or liquids? ☐ Yes ☐ No	Comments:
Special Formulas? ☐ Yes ☐ No	Feeding Tube? ☐ Yes ☐ No	Comments:
Does your child have a dietician? ☐ Yes ☐ No	List other concerns?	
Dietician's First and Last Name, Practice/Location and Phone Number		Date Last Seen?
Name:		
Address:		
Phone:		

Therapies Being Received?

Speech? ☐ Yes ☐ No	Physical? ☐ Yes ☐ No	Occupational? ☐ Yes ☐ No	Other?

Medical Equipment Being Used (circle all that apply)

Wheelchair	**Walker**	**Crutches**	**Orthotics (foot/ankle)**	**Braces (orthopedic)**	**Braces (orthodontia)**	**Hearing Aids**	**Glasses**	**Glucose Monitor**
Feeding Tube or supplies	**Feeding Pump**	**Apnea Monitor**	**Oxygen**	**Ventilator**	**Aerosol Machine**	**Other**		

Medical Diagnoses, Health and Healthcare Concerns?

Do you have any concerns regarding your child's health or healthcare at this time? ☐ Yes ☐ No
If yes, please explain:
Please list all medical diagnoses and current medications for your child [attach add'l sheets, as needed]:

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