Exhibit 1

UCDJFS FOSTER CARE PLACEMENT COMMUNICABLE DISEASE SCREENING

*ODJFS rules and UCDJFS policy require this form to be completed **within two (2) days of initial placement**. Please contact the Union County Health Department at (937) 642-0801 Monday through Friday to schedule this screening. See Exhibit 2 of the contract to determine the protocol for accessing health department staff during non-business hours.*

Child's Name: ______________________ DOB: ______________ Sex: F M

Height: __________ Weight: __________ T ______ P ______ R ______

General Appearance:

Eyes ____

Throat ____

Neck ____

Lungs ____

Skin (rash, scabies, lesions, bruises) ________________________

Hair & Scalp (lice or nits) ________________________

Regular Medications: (List meds and the conditions associated with the meds)

____

____

____

Known Allergies: ____

Current Doctor: ____

Dentist: ____

Eye Doctor: ____

Sleep Patterns:

Time Rising: __________ Sleep Walking: __________

Bedtime: __________ Talks in Sleep: __________

Nightmares: __________ Bedwetting: __________

General Comments and/or Recommendations: ________________________

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*The following sections are **optional** (but we prefer this is covered) when examining adolescents:*

Tobacco/Substance Use: ______________________________

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____

Menstrual History:

Menarche ____________ LMP ____________

Cramps ____________ Regular ____________

Irregular ____________

Sexual History:	Yes	No	Comments
Sexually Active	☐	☐	____________
Using Birth Control	☐	☐	____________
Using STD Protection	☐	☐	____________
Vaginal/Penile Discharge	☐	☐	____________
Itching	☐	☐	____________
Burning	☐	☐	____________

Comments/Recommendations: ______________________________

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I have examined this child who, at this time, appears to be free from communicable diseases.

Name: ____________ Signature: ____________

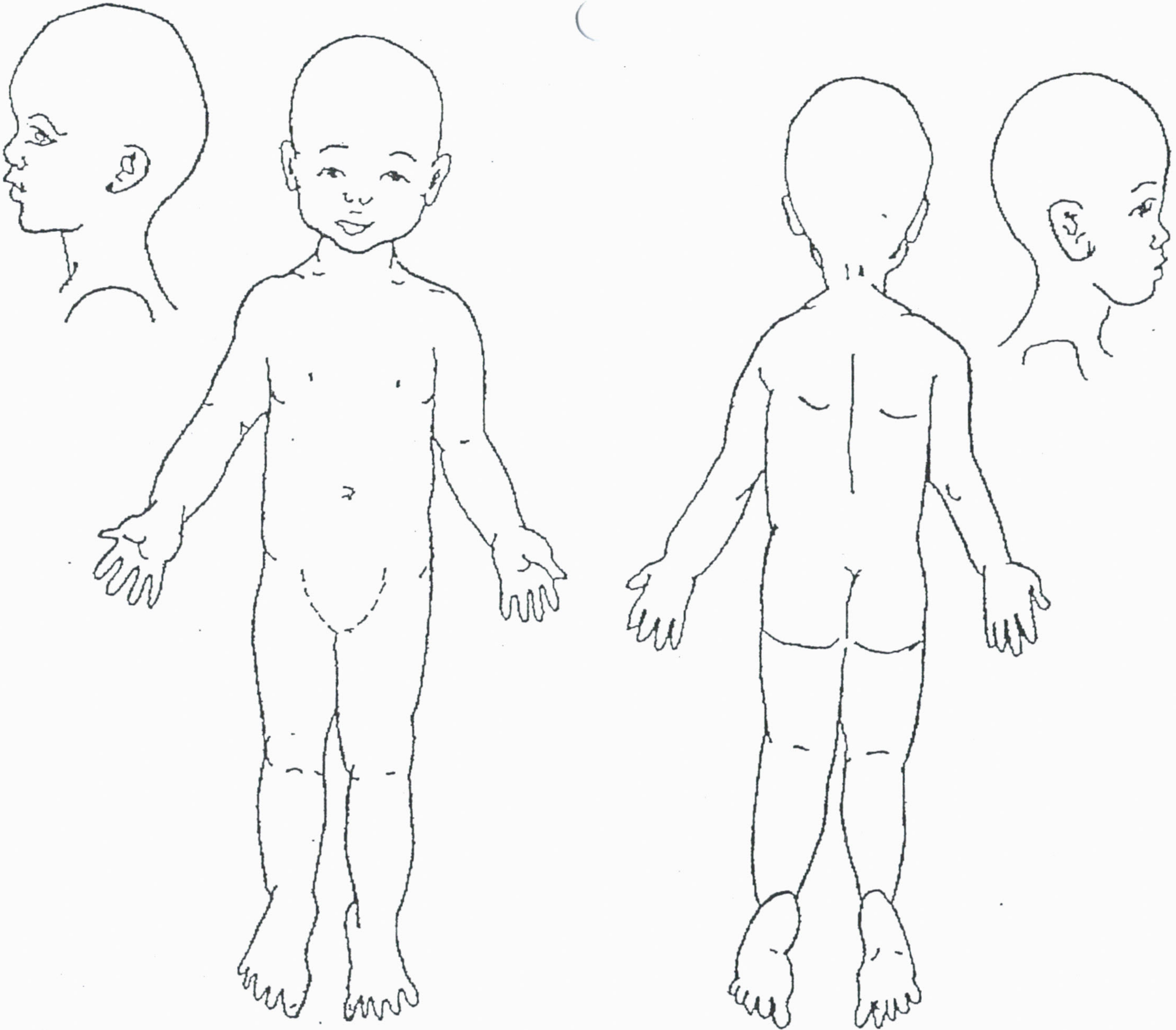
Title: ____________ Date: ____________

I have examined this child who, at this time, <u>does not</u> appear to be free from communicable diseases and should be seen by a licensed physician.

Name: ____________ Signature: ____________

Title: ____________ Date: ____________

INJURY IDENTIFICATION SHEET



INSTRUCTIONS:

A. Locate and number each injury on drawings.
B. Indicate approximate shape of each injury on drawing.