This HPP is to be completed for each child in care within four weeks of placement. It is to be kept with the child while in care and accompanies the child when the child is returned home, placed in a permanent placement or when the child is emancipated from care. The HPP documents should be photocopied periodically and the copies kept in the case file.

**R517**

**Department of Human Services**

**Division of Child Welfare**

**System Report**

**Health Passport (HPP)**

**GENERAL INFORMATION**

**Middle Name**

**Suffix**

**Last Name**

**First Name**

LASTNAME

L

FIRSTNAME

**Date of Birth**

**Gender**

**State ID**

**Age**

mm/dd/yyyy

gender

Z999999

years

**Height**

**Hair Color**

**Eye Color**

**Current Weight**

lbs

**MEDICAL HISTORY / CONDITIONS**

**Physical/Medical/Developmental (Observed)**

Failure to Thrive-Non-Organic

**MEDICAL AND DENTAL PROVIDERS**

**Provider Name/Address**

Medical

**Provider Phone:**

**Provider Type:**

1925 Orman

City CO 99999-4

(999) 999-9999

Pediatrician

**Start Date:**

mm/dd/yyyy

**End Date:**

**Comments:**

**Provider Name/Address**

Medical

**Provider Phone:**

**Provider Type:**

Street

City CO 99999-4

(999) 999-9999

Pediatrician

**Start Date:**

mm/dd/yyyy

**End Date:**

**Comments:**

(999) 999-9999

**Agency Phone:**

Street

CITY CO 99999-1

Cntr Pc

**Agency Name/Address**

**Start Date:**

mm/dd/yyyy

**End Date:**

**Comments:**

**Provider Name/Address**

Medical

**Provider Phone:**

**Provider Type:**

Street

CITY CO 99999-5

(999) 999-9999

Dentist

**Start Date:**

mm/dd/yyyy

**End Date:**

**Comments:**

**Provider Name/Address**

Medical

**Provider Phone:**

**Provider Type:**

Street

CITY CO 99999-4

(999) 999-9999

Physician

**Start Date:**

mm/dd/yyyy

**End Date:**

**Comments:**

**Run Date/Time :** mm/dd/yyyy 2:45PM

Page 1 of 4

**CM 1.0**

**Health Passport**

**APPOINTMENTS/ HOSPITALIZATIONS**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Pediatrician

**Appt Type:**

Well-Child Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Dentist

Dentist

**Appt Status:**

Held

**Appt Type:**

Dental Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Status:**

Held

**Appt Type:**

Well-Child Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Agency Name:**

Cntr Pc

**Appt Status:**

Held

**Appt Type:**

Other Medical Speciality

**Reason:**

eye exam

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Dentist

Dentist

**Appt Status:**

Held

**Appt Type:**

Dental Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Dentist

Dentist

**Appt Status:**

Held

**Appt Type:**

Dental Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Type:**

Medical Follow Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Status:**

Held

**Appt Type:**

Well-Child Check Up

**Reason:**

**Run Date/Time :** mm/dd/yyyy 2:45PM

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**CM 1.0**

**R517 Health Passport**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Type:**

Medical Follow Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Type:**

Medical Follow Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Type:**

Medical Follow Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Pediatrician

**Appt Status:**

Held

**Appt Type:**

Well-Child Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Agency Name:**

Rocky Mountain Eye Cntr Pc

**Appt Status:**

Held

**Appt Type:**

Other Medical Speciality

**Reason:**

eye

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Dentist

Dentist

**Appt Status:**

Held

**Appt Type:**

Dental Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Dentist

Dentist

**Appt Status:**

Held

**Appt Type:**

Dental Check Up

**Reason:**

**Scheduled Date:**

**Date of Appointment:**

mm/dd/yyyy

**Provider Type:**

**Provider Name:**

Doctor

Physician

**Appt Status:**

Held

**Appt Type:**

Well-Child Check Up

**Reason:**

**Run Date/Time :** mm/dd/yyyy 2:45PM

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**CM 1.0**

**R517 Health Passport**

**Date Given**

**Immunization Type**

**Doctor/Clinic**

**Next Due Date**

**IMMUNIZATION**

mm/dd/yyyy

Influenza Dose 2

mm/dd/yyyy

Influenza Dose 1

mm/dd/yyyy

Pneumococcal

mm/dd/yyyy

MMR/MR Dose 2

mm/dd/yyyy

OPV/IPV - Dose 4

mm/dd/yyyy

DTap/Tdap/DT - Dose 5

mm/dd/yyyy

OPV/IPV - Dose 3

mm/dd/yyyy

HIB

mm/dd/yyyy

DTap/Tdap/DT - Dose 4

mm/dd/yyyy

MMR/MR Dose 1

mm/dd/yyyy

Hepatitis B Dose 3

mm/dd/yyyy

Varicella

mm/dd/yyyy

DTap/Tdap/DT - Dose 3

mm/dd/yyyy

HIB

mm/dd/yyyy

OPV/IPV - Dose 2

mm/dd/yyyy

Hepatitis B Dose 2

mm/dd/yyyy

HIB

mm/dd/yyyy

DTap/Tdap/DT - Dose 2

mm/dd/yyyy

OPV/IPV - Dose 1

mm/dd/yyyy

DTap/Tdap/DT - Dose 1

mm/dd/yyyy

HIB

mm/dd/yyyy

Hepatitis B Dose 1

**School Name**

**Current Grade Level**

**Status**

**Last Attend**

**Date**

**Begin Attend**

**Date**

**School District**

**SCHOOL/ EDUCATION**

School

mm/dd/yyyy

Attending

Grade x

School

mm/dd/yyyy

mm/dd/yyyy

Attending

Grade x

**Run Date/Time :** mm/dd/yyyy 2:45PM

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**CM 1.0**