

Child Foster Care Placement Information

*This form should be given to foster parent(s) by the placing social worker
at the time the child(ren) is placed in the foster home.*

FILL OUT 1 FORM FOR EACH CHILD

Type of Placement: _____

Child's Name: _____ Age: _____ Daily Rate: _____ DOB: _____ Gender: _____

Sibling Group Names: _____ DOB: _____ Gender: _____

_____ DOB: _____ Gender: _____

_____ DOB: _____ Gender: _____

Case Management / Placing Social Worker's Contact Information

Name: _____

Office Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Means of Communication: _____

Family Information

Mother's Name: _____

Home Phone: _____ Cell Phone: _____

Father's Name: _____

Home Phone: _____ Cell Phone: _____

Who has Custody of the Children: _____

Is Phone Contact with their Parents/Relatives Allowed: Yes No Calls Should be Supervised: Yes No

*** Please describe further limitations / expectations regarding contact with family in the **Visitation Section** ***

Family's Spiritual Affiliation: _____

Medical Information

Has the foster parent been provided a copy of the child's medical assistance card or a letter granting permission for the foster parent to seek medical services? Yes No

Where has the child received medical treatment? _____

Where has the child received dental treatment? _____

Where has the child received vision treatment? _____

Does the child have any **food or medication allergies or health concerns**? _____

Important Case Planning Information

Reason for current foster care placement: _____

Any Already scheduled appointments or court hearings the foster parents should be aware of: _____

Placement History

Location: _____ Date Entered: _____ Date Left: _____

Location: _____ Date Entered: _____ Date Left: _____

Location: _____ Date Entered: _____ Date Left: _____

Personal Needs

Abuse/Neglect/Trauma History:

Mental Health Diagnoses / Physical Disabilities or Needs:

Typical Behaviors for the child:

Child's strengths and support system:

Supervision Expectations (can they be left home alone, can they go out with friends, are there computer or cell phone limitations, etc):

Specific routines or significant objects the foster parent should be aware of in order to help the child feel more comforted as they come into foster care:

On-going Therapy Expectations:

Medication Management

Medication Name	Can The Child Self-Medicat?	Will Medication Be With Child?	When Will Refill Be Needed?

Significant People or Collateral Contact Information (therapists, etc)

Name: _____ Role: _____

Agency: _____

Office Phone: _____ Cell Phone: _____

Email _____

Address: _____

Name: _____ Role: _____

Agency: _____

Office Phone: _____ Cell Phone: _____

Email _____

Address: _____

Educational Information

School: _____ Grade Level: _____

School Start Time: _____ School End Time: _____

Will bussing be established? _____ Who is responsible to set up bussing? _____

Special Education Services or special services in place (Please describe):

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Is this child participating in after school activities? _____

Visitation Information

Describe visitation expectations for this child.

Name	Relationship	Frequency	Location	Transportation for Children	Who Will Schedule Visits

Are there any individuals with whom this child should not have any contact? Please provide any relevant detail information.

Any Information the Foster Parent should follow up on right away (appointments, etc):

Is there a preferred medical clinic or mental health professional for the child?

Other Important Information:

Case Manager Signature: _____

Date Given: _____

Foster Parent Signature: _____

Date Received: _____