Child Residential Licensing- Child Health and Safety Assessment
55 Pa.Code § 3800.141(a)-(c)

* The health and safety assessment should be a "living document" and must be kept accurate throughout the child's stay at the facility.
* In accordance to §3800.142 if the health and safety assessment identifies a health or safety risk a written plan to protect the child shall be developed and implemented within 24 hours after the assessment is completed

Resident and Evaluation Information

Name:	Date of Birth:	Date of Arrival:	Date and Time of completed assessment:

(1) Medical Information and Health Concerns

Allergies	Medications	Immunization History	Hospitalizations
☐ None ☐ Listed Below:	☐ None ☐ Listed Below:	Are immunizations current? ☐ Yes ☐ No ☐ Unknown	☐ None ☐ Listed Below:
Medical Diagnoses	**Medical Problems that run in the Family**	**Issues experienced by the child's mother during pregnancy**	**Special Dietary Needs**
☐ None ☐ Listed Below:	☐ None ☐ Listed Below:	☐ None ☐ Listed Below:	☐ None ☐ Listed Below:
Illnesses	**Injuries**	**Body Positioning & Movement stimulation for children with disabilities**	**Ongoing Medical Care Needs**
☐ None ☐ Listed Below:	☐ None ☐ Listed Below:	☐ None ☐ Listed Below:	☐ None ☐ Listed Below:

Dental Problems	Mental Problems	Emotional Problems
☐ None ☐ Listed Below:	☐ None ☐ Listed Below:	☐ None ☐ Listed Below:

(2) Suicide/Self Injury Assessment

Known or suspected suicide or self-injury attempts or gestures and emotional history which may indicate a predisposition for self-injury or suicide:

☐ Yes ☐ No If yes, provide the date(s) of any attempts and details:

(3) Aggressive or Violent Behavior

Known incidents of aggressive or violent behavior: ☐ Yes ☐ No If yes, provide the date(s) and details:

(4) Substance Abuse History

Known incidents of substance abuse: ☐ Yes ☐ No If yes, provide details (frequency, type of substance, last used):

(5) Sexual History

Sexual history or behavior patterns that may place the child or other children at a health or safety: ☐ Yes ☐ No

Medical Professional Information

By signing below, I certify that:

- A medical personnel or staff persons trained by medical personnel.

Printed Name:	Signature:

Health and Safety Assessment Addendum Revisions			
Date:	Description of Revision	Name of individual completing revision	Was a Safety Plan created?