CHILD'S DETAILS

INFORMATION FROM THE CHILD INFORMATION FORM (CIF)
SHOULD BE INCLUDED HERE.

NAME	DATE OF BIRTH
ADDRESS	
EMERGENCY CONTACT NAME	TELEPHONE
FIRST LANGUAGE	INTERPRETER REQUIRED ☐ YES ☐ NO
MEDICARE NUMBER	EXPIRY DATE
HEALTH CARE CARD	EXPIRY DATE
MEDIC ALERT ☐ YES ☐ NO DETAILS	
TELEPHONE	
GENDER ☐ MALE ☐ FEMALE	
CASE MANAGER	
DISTRICT	DATE ENTERED CARE

IF FOUND PLEASE RETURN TO

____

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NAME	DATE OF BIRTH
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GENDER ☐ MALE ☐ FEMALE	
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DISTRICT	DATE ENTERED CARE

IF FOUND PLEASE RETURN TO

____

PREVIOUS HEALTH BACKGROUND OR MEDICAL CONDITIONS

INSERT ANY HEALTH BACKGROUND HISTORY IDENTIFIED FROM THE CIF.

DATE OF ENTRY	MEDICAL CONDITIONS / HOSPITAL ADMISSIONS - HISTORY
	ENTERED BY

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	ENTERED BY

DATE OF ENTRY	MEDICAL CONDITIONS / HOSPITAL ADMISSIONS - HISTORY
	ENTERED BY

HEALTH PROFESSIONAL DETAILS

GENERAL PRACTITIONER

NAME		
ADDRESS		
SUBURB/TOWN/CITY	STATE	POSTCODE
TELEPHONE	FAX	
EMAIL		
DATE OF FIRST APPOINTMENT/CONTACT WITH CHILD		

HEALTH NURSE

NAME		
ADDRESS		
SUBURB/TOWN/CITY	STATE	POSTCODE
TELEPHONE	FAX	
EMAIL		
DATE OF FIRST APPOINTMENT/CONTACT WITH CHILD		

DENTIST

NAME		
ADDRESS		
SUBURB/TOWN/CITY	STATE	POSTCODE
TELEPHONE	FAX	
EMAIL		
DATE OF FIRST APPOINTMENT/CONTACT WITH CHILD		

HEALTH PROFESSIONAL DETAILS

OTHER HEALTH PROFESSIONALS

NAME		
PROFESSION		
ADDRESS		
SUBURB/TOWN/CITY	STATE	POSTCODE
TELEPHONE	FAX	
EMAIL		
DATE OF FIRST APPOINTMENT/CONTACT WITH CHILD		

NAME		
PROFESSION		
ADDRESS		
SUBURB/TOWN/CITY	STATE	POSTCODE
TELEPHONE	FAX	
EMAIL		
DATE OF FIRST APPOINTMENT/CONTACT WITH CHILD		

NAME		
PROFESSION		
ADDRESS		
SUBURB/TOWN/CITY	STATE	POSTCODE
TELEPHONE	FAX	
EMAIL		
DATE OF FIRST APPOINTMENT/CONTACT WITH CHILD		

APPOINTMENTS WITH DOCTORS/NURSES

DOCTOR/NURSE NAME
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
OTHER
ADDITIONAL COMMENTS
REFERRALS

DOCTOR/NURSE NAME
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
OTHER
ADDITIONAL COMMENTS
REFERRALS

APPOINTMENTS WITH DOCTORS/NURSES

DOCTOR/NURSE NAME
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
OTHER
ADDITIONAL COMMENTS
REFERRALS

DOCTOR/NURSE NAME
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
OTHER
ADDITIONAL COMMENTS
REFERRALS

APPOINTMENTS WITH DENTAL PROFESSIONALS OR SCHOOL DENTISTS

DENTAL PROFESSIONAL NAME	
DATE OF APPOINTMENT	
REASON FOR APPOINTMENT	☐ CHECK UP ☐ CLEANING ☐ CAVITY ☐ OTHER
IF OTHER (PLEASE SPECIFY)	
ADDITIONAL COMMENTS	
REFERRALS	

DENTAL PROFESSIONAL NAME	
DATE OF APPOINTMENT	
REASON FOR APPOINTMENT	☐ CHECK UP ☐ CLEANING ☐ CAVITY ☐ OTHER
IF OTHER (PLEASE SPECIFY)	
ADDITIONAL COMMENTS	
REFERRALS	

APPOINTMENTS WITH DENTAL PROFESSIONALS OR SCHOOL DENTISTS

DENTAL PROFESSIONAL NAME	
DATE OF APPOINTMENT	
REASON FOR APPOINTMENT	☐ CHECK UP ☐ CLEANING ☐ CAVITY ☐ OTHER
IF OTHER (PLEASE SPECIFY)	
ADDITIONAL COMMENTS	
REFERRALS	

DENTAL PROFESSIONAL NAME	
DATE OF APPOINTMENT	
REASON FOR APPOINTMENT	☐ CHECK UP ☐ CLEANING ☐ CAVITY ☐ OTHER
IF OTHER (PLEASE SPECIFY)	
ADDITIONAL COMMENTS	
REFERRALS	

MEDICATIONS (PAST AND PRESENT)

MEDICATION	DOSAGE
CONDITION/S	
DATE BEGAN TAKING	DATE STOPPED TAKING
REACTIONS, OUTCOMES OR COMMENTS	
PRESCRIBING HEALTH PROFESSIONAL	

MEDICATION	DOSAGE
CONDITION	
DATE BEGAN TAKING	DATE STOPPED TAKING
REACTIONS, OUTCOMES OR COMMENTS	
PRESCRIBING HEALTH PROFESSIONAL	

MEDICATIONS (PAST AND PRESENT)

MEDICATION	DOSAGE
CONDITION/S	
DATE BEGAN TAKING	DATE STOPPED TAKING
REACTIONS, OUTCOMES OR COMMENTS	
PRESCRIBING HEALTH PROFESSIONAL	

MEDICATION	DOSAGE
CONDITION	
DATE BEGAN TAKING	DATE STOPPED TAKING
REACTIONS, OUTCOMES OR COMMENTS	
PRESCRIBING HEALTH PROFESSIONAL	

APPOINTMENTS WITH OTHER HEALTH PROFESSIONALS OR SPECIALISTS

NAME
PROFESSION
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
ACTIONS REQUIRED
OTHER

NAME
PROFESSION
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
ACTIONS REQUIRED
OTHER

APPOINTMENTS WITH OTHER HEALTH PROFESSIONALS OR SPECIALISTS

NAME
PROFESSION
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
ACTIONS REQUIRED
OTHER

NAME
PROFESSION
DATE OF APPOINTMENT
REASON FOR APPOINTMENT
ACTIONS REQUIRED
OTHER

IMMUNISATION RECORD

INSERT INFORMATION FROM THE CHILDHOOD VACCINATION RECORD CARD

An Immunisation History Statement from the Australian Childhood Immunisation Register can be inserted into the passport here instead.

VACCINE	DATE GIVEN

VACCINATIONS OR IMMUNISATIONS DUE OVER THE NEXT 12 MONTHS

VACCINE	DATE DUE

IMMUNISATION RECORD

INSERT INFORMATION FROM THE CHILDHOOD VACCINATION RECORD CARD

An Immunisation History Statement from the Australian Childhood Immunisation Register can be inserted into the passport here instead.

VACCINE	DATE GIVEN

VACCINATIONS OR IMMUNISATIONS DUE OVER THE NEXT 12 MONTHS

VACCINE	DATE DUE

CARER'S FEEDBACK

Please let us know what you think about this Child Health Passport. We'd love to hear your opinion. Simply fill out this form and forward to:

Department for Child Protection
Corporate Communications
Reply Paid 83796
EAST PERTH WA 6004

Name (optional): ______________________

____

Age of child in your care: _______________

Do you take this Health Passport with you to the child's health appointments?

- ☐ Yes
- ☐ No

Comments:

Do you find the information in the child's Health Passport useful?

- ☐ Yes
- ☐ No

Comments:

Is there any other health information that could be added to the Passport?

Comments:

CHILD'S FEEDBACK

Tell us what you think about your Child Health Passport!
Your feedback is valuable:

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