**What is this form?**

All local authority officers and our partners have a duty to provide good quality and timely services to ensure the best possible outcomes for looked after children. It is vitally important that services work together to ensure a caring, stable environment for your child. When a child becomes a “looked after child” Derbyshire County Council and NHS health partners have a legal responsibility to form a “health care plan” within the first 20 days. This care plan helps us to understand your child and their needs, and helps them with their new environment.

In order to compile this Health Care Plan a **health assessment** is needed for your child. If you complete this form, a member of the NHS health team will be able to access the child’s health history and develop a complete care plan to ensure your child’s is cared for in respect of their health and well-being.

**Equality and Diversity**

Derbyshire County Council and the NHS are committed to supporting children and young people from a wide range of ethnic and cultural backgrounds living in a variety of family settings, economic and social circumstances. The working practice reflected in the care plan aims to meet your child’s needs taking account their special needs, race, religious beliefs and faith, gender and sexuality.

**What about confidentiality?**

We will treat all the information we receive as confidential. We will only collect information relating to the child, and only use the information as part of the health care plan. The information will not be sold or used for any other purpose.

**If you do not agree**

In the first instance, we would try and ask your child. We recognise your child should be able to participate in decisions about their health care, and if they are capable of understanding what is involved, and are capable of answering, then we will get their consent. If they are unable (they might be too young to understand, for example), then we will ask you for your consent.

**If you say no, then the care plan will be incomplete and we will be unable to do our absolute best for your child.** In some circumstances, where we feel there is a question over safeguarding then we may proceed without getting your consent.

**What is the legal basis?**

There is a law called the Children Act 1989 (and 2004) which is all about the child. Making a care plan and having regular health assessments for a ‘looked after child’ is part of this law, however we need your consent for the health assessments and we have to get this information within 20 days of your child coming into our care.

Once we have the consent, we will instruct our health partners to provide the health assessment in line with the requirements within the law. Once we have asked them to do so, they have a legal obligation under the Data Protection Act 2018 to share this information with us.

**What about your health history?**

It is possible that having the health history of you as birth parents will help us provide the absolute best care plan for the child. Therefore, we are also asking you to allow the health team to access your health record too. This will only form part of the child’s care plan, and will not be shared outside of the needs of the care plan.

**Health Consent Form**

**Name of child: DOB:**

1. **Consent to health care and medical treatment**

I agree for Statutory Health Assessments (Initial and Review Health Assessments) to be undertaken on the above child for the time they are in care of the Local Authority and access to the child’s health history (including birth/neonatal history)

**YES / NO**

Emergency medical examinations and treatment including anaesthetics

**YES / NO**

**YES / NO**

I agree to share my child’s health information with professionals in the best interest of my child

Routine Medical and dental examinations or treatment, including immunisations, orthotics’ (eye check), audiology (hearing assessments) and paediatric reviews, deemed to be in the best interest of my child by an appropriately qualified health professional.

**YES / NO**

Please indicate any medical treatment or particular immunisations to which you do not give your consent. Please explain the reasons why.

The issue of consent for health assessments and treatment has been explained and understood by me (as parental responsibility holder)

**YES / NO**

**YES / NO**

Parent/s: The social worker has discussed with me why the issue of consent is important to the welfare of my child

**Signature:……………………………………............. Name: ………………………………………….. Date: …………………**

**Relationship/Role: …………………………………………..** (TO BE SIGNED BY PARENT/S OR PARENTAL RESPONSIBILITY HOLDER)

**Witness Signature:…………………….……......... Name: ………………………………………….. Date: …………………**

**Relationship/Role: - Social Worker**

**Signature:……………………………………............. Name: ………………………………………….. Date: …………………**

**Relationship/Role: - Head of Service Locality**

1. **Consent to access and share parental health history in the best interest of your child**

The following consent is given on the understanding that any information will be treated in confidence and only **shared when it is important to my child’s care or well-being.**

I agree for the health professionals to access/share health information and a health history about me, the biological **mother** (for example: maternity, health conditions and emotional health)**.**

**YES / NO / NA**

Mother’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Witnessed by :***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree for the health professionals to access/share health information and a health history about me, the biological **father** (for example: health conditions and emotional health)**.**

**YES / NO / NA**

Father’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Witnessed by :***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The attached coramBAAF Form – PH** (parental health) should be completed with biological mother and biological father (separate form for each). On completion this should be sent back to the relevant health admin.

**IHA - Part A and Derbyshire Form A**

**Essential Information to be completed by Business Services/Social Worker**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s First Name |  | Child’s Last Name |  |
| Likes to be known as |  | Also previously known as |  |
| DOB |  | Sex | M / F |
| NHS Number |  | LCS Case No |  |
| Interpreter Required? | YES / NO | Arranged? | YES / NO |
| First Language |  | Second Language |  |
| Ethnic Origin |  | Religion |  |
| Legal Status  |  | Current Legal Proceedings |  |
| Date first looked after at this episode |  | School/nursery/other day care |  |
| No. of previous placements in the last 12 months (inc birth) |  |
| Reasons for being looked after  |  |
| Social Care History of Child / Family |  |
| Any concerning parental health / lifestyle issues that may impact the child’s health  |  |
| Any significant information about the child |  |

**Birth Family:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Mother:** Name |  | DOB |  |
| Address |  |
| Ethnicity |  | Religion |  |
| First Language |  | Second Language |  |
| Contact arrangements |  |
| **Father:** Name |  | DOB |  |
| Address |  |
| Ethnicity |  | Religion |  |
| First Language |  | Second Language |  |
| Contact arrangements |  |
| **Siblings:** Names and DOB |  |
| Whereabouts of the siblings |  |
| Contact arrangements |  |
| **Name of GP** |  |
| Address, inc post code |  |
| Telephone Number |  |
| **Current carers**  |
| Date placement started |  |
| Name |  |
| Address, inc post code |  |
| Telephone |  |
| Languages spoken |  |
| Relationship to the child? |  |

**Agency Details:**

|  |  |
| --- | --- |
| Name of agency | Derbyshire County Council |
| Name of Social Worker |  |
| Telephone number |  | Email address |  |
| Social Workers Manager’s name |  |
| Managers telephone number |  | Managers email address |  |
| Child and family details section completed by: |  | Date |  |
| Telephone  |  | Email |  |

**coramBAAF Form PH** LOOKED AFTER CHILDREN

Child : D.O.B : NHS no :

**Report on health of birth MOTHER NAME :**

**Parent’s consent to the sharing of health information**

The signed Consent Form (or photocopy) **must** be attached to this form

**Part B -** should be completed by the birth parent together with the social worker. **Note:** each birth parent should complete a separate form.

**Purpose of the form:**

* To provide information that will contribute to the care of the child’s health, both currently and in the future.
* To provide a family health history that will assist in planning for the child’s placement.
* To provide an opportunity to discuss with birth parents the health history of their extended families that, in view of increasing genetic knowledge, could prove to be of importance throughout their child’s life and possibly for their children as well.
* To demonstrate to the child later on that their birth parents gave thought and consideration to their child’s future welfare.

**Part B To be completed by the birth MOTHER, with the social worker**

1. In the following questions please circle yes or no.

**Are you in good health now?** Yes/No

If no please give details

**Are you seeing any specialist or hospital consultant?** Yes/No

If yes i) Who is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ii) Which hospital/unit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 iii) What do you see him/her for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking any medicines or tablets regularly?** Yes/No

If yes what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you take any medicines or tablets during pregnancy?** Yes/No

If yes what did you take and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any significant physical or mental health problems in the past?** Yes/No

If yes please give details

**2. Personal health history**

**Have you ever suffered from or been treated for any of the following?**

(Please indicate yes/no and give details)

N/

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Details** |
| Epilepsy or fits  |  |  |  |
| High blood pressure/heart problems, e.g. age under 60 at first heart attack |  |  |  |
| Stroke |  |  |  |
| High cholesterol or lipids/fats |  |  |  |
| Blood clots in leg or lung (thrombosis) |  |  |  |
| Asthma/bronchitis or chest problems |  |  |  |
| Jaundice or hepatitis |  |  |  |
| Digestive or bowel problems |  |  |  |
| Kidney or bladder problems |  |  |  |
| Diabetes |  |  |  |
| Thyroid problems |  |  |  |
| Skin conditions |  |  |  |
| Arthritis or joint problems |  |  |  |
| Sight problems, e.g. lazy eye, glaucoma, wear glasses |  |  |  |
| Hearing problems, e.g. grommets |  |  |  |
| Allergies |  |  |  |
| Serious reaction to general anaesthetic |  |  |  |
| Investigated or treated for cancer |  |  |  |
| TB |  |  |  |
| Any other serious physical illness |  |  |  |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Emotional problems |  |  |  |
| Other mental health diagnosis |  |  |  |
| Other |  |  |  |

**3. Have you been tested for any of the following:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Result** | **Date** |
| Blood fats or cholesterol |  |  |  |  |
| Thalassaemia |  |  |  |  |
| Sickle cell disease |  |  |  |  |
| Sexually acquired infections, including syphilis |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Hepatitis C |  |  |  |  |
| HIV |  |  |  |  |

**4. Please tell me about your lifestyle**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you or did you ever?** | **No** | **Yes – current use and quantity per day**  | **Yes – past use and quantity per day** | **Used in pregnancy? At what stage?** |
| Smoke tobacco  |  |  |  |  |
| Use alcohol |  |  |  |  |
| Use drugs: cannabis/skunk |  |  |  |  |
| Heroin |  |  |  |  |
| Methadone |  |  |  |  |
| Subutex |  |  |  |  |
| Cocaine/crack |  |  |  |  |
| Amphetamines |  |  |  |  |
| Tranquillisers/ benzodiazepines |  |  |  |  |
| Other (give names) |  |  |  |  |
| Inject drugs |  |  |  |  |

1. **What is your height? .........................**

**What is your weight? .........................**

1. **Do you have or have you ever had problems with**:

|  |
| --- |
| Do Reading |
| W Writing, or filling in forms |
| Spelling |
| Using numbers |
| Speech and language, including autism or Asperger’s |
| Concentration and attention/ADHD/hyperactivity |

Did you receive extra support in school?

Did you attend a special school/unit? Give reason, e.g. behaviour, learning difficulties, other

**7. Family history**

Please tell me about the health of your family. Does anyone have any serious health problems, such as those listed in section 2? Does anyone have any genetic conditions that may run in the family?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Age now**  | **State of health if living**  | **Cause of, and age at death**  |
| Father  |  |  |  |
| Mother  |  |  |  |
| Your brothers and sisters |  |  |  |
| Your children |  |  |  |
| Other |  |  |  |

|  |  |
| --- | --- |
| **Has anyone in your family, either now, or in the past, had:** | **State their relationship to you and give details of their difficulty** |
| Learning difficulties |  |
| Reading/writing difficulties |  |
| Special schooling |  |
| Mental health problems; please specify, e.g. drug or alcohol dependency, suicide, depression |  |

**8. Is there anything else about the health of yourself or any other family member that you would like to include?**

**Parent’s signature / Name** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social worker’s / witness’s signature** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Source of information if parent is unable to provide it

**coramBAAF Form PH** LOOKED AFTER CHILDREN

Child : D.O.B : NHS no :

**Report on health of birth FATHER NAME :**

**Parent’s consent to the sharing of health information**

The signed Consent Form (or photocopy) **must** be attached to this form

**Part B** should be completed by the birth parent together with the social worker. **Note:** each birth parent should complete a separate form.

**Purpose of the form:**

* To provide information that will contribute to the care of the child’s health, both currently and in the future.
* To provide a family health history that will assist in planning for the child’s placement.
* To provide an opportunity to discuss with birth parents the health history of their extended families that, in view of increasing genetic knowledge, could prove to be of importance throughout their child’s life and possibly for their children as well.
* To demonstrate to the child later on that their birth parents gave thought and consideration to their child’s future welfare.

**Part B To be completed by the birth FATHER, with the social worker**

1. In the following questions please circle yes or no.

**Are you in good health now?** Yes/No

If no please give details

**Are you seeing any specialist or hospital consultant?** Yes/No

If yes i) Who is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ii) Which hospital/unit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 iii) What do you see him/her for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking any medicines or tablets regularly?** Yes/No

If yes what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any significant physical or mental health problems in the past?** Yes/No

If yes please give details

**2. Personal health history**

**Have you ever suffered from or been treated for any of the following?**

(Please indicate yes/no and give details)

N/

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Details** |
| Epilepsy or fits  |  |  |  |
| High blood pressure/heart problems, e.g. age under 60 at first heart attack |  |  |  |
| Stroke |  |  |  |
| High cholesterol or lipids/fats |  |  |  |
| Blood clots in leg or lung (thrombosis) |  |  |  |
| Asthma/bronchitis or chest problems |  |  |  |
| Jaundice or hepatitis |  |  |  |
| Digestive or bowel problems |  |  |  |
| Kidney or bladder problems |  |  |  |
| Diabetes |  |  |  |
| Thyroid problems |  |  |  |
| Skin conditions |  |  |  |
| Arthritis or joint problems |  |  |  |
| Sight problems, e.g. lazy eye, glaucoma, wear glasses |  |  |  |
| Hearing problems, e.g. grommets |  |  |  |
| Allergies |  |  |  |
| Serious reaction to general anaesthetic |  |  |  |
| Investigated or treated for cancer |  |  |  |
| TB |  |  |  |
| Any other serious physical illness |  |  |  |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Emotional problems |  |  |  |
| Other mental health diagnosis |  |  |  |
| Other |  |  |  |

1. **Have you been tested for any of the following:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Result** | **Date** |
| Blood fats or cholesterol |  |  |  |  |
| Thalassaemia |  |  |  |  |
| Sickle cell disease |  |  |  |  |
| Sexually acquired infections, including syphilis |  |  |  |  |
| Hepatitis B |  |  |  |  |
| Hepatitis C |  |  |  |  |
| HIV |  |  |  |  |

**4. Please tell me about your lifestyle**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you or did you ever?** | **No** | **Yes – current use and quantity per day**  | **Yes – past use and quantity per day** | **Used in pregnancy? At what stage?** |
| Smoke tobacco  |  |  |  |  |
| Use alcohol |  |  |  |  |
| Use drugs: cannabis/skunk |  |  |  |  |
| Heroin |  |  |  |  |
| Methadone |  |  |  |  |
| Subutex |  |  |  |  |
| Cocaine/crack |  |  |  |  |
| Amphetamines |  |  |  |  |
| Tranquillisers/ benzodiazepines |  |  |  |  |
| Other (give names) |  |  |  |  |
| Inject drugs |  |  |  |  |

**5. What is your height? …………………………….**

**What is your weight? …………………………….**

1. **Do you have or have you ever had problems with**:

|  |
| --- |
| **Do** Reading |
| W Writing, or filling in forms |
| Spelling |
| Using numbers |
| Speech and language, including autism or Asperger’s |
| Concentration and attention/ADHD/hyperactivity |

Did you receive extra support in school?

Did you attend a special school/unit? Give reason, e.g. behaviour, learning difficulties, other

**7. Family history**

Please tell me about the health of your family. Does anyone have any serious health problems, such as those listed in section 2? Does anyone have any genetic conditions that may run in the family?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Age now**  | **State of health if living**  | **Cause of, and age at death**  |
| Father  |  |  |  |
| Mother  |  |  |  |
| Your brothers and sisters |  |  |  |
| Your children |  |  |  |
| Other |  |  |  |

|  |  |
| --- | --- |
| **Has anyone in your family, either now, or in the past, had:** | **State their relationship to you and give details of their difficulty** |
| Learning difficulties |  |
| Reading/writing difficulties |  |
| Special schooling |  |
| Mental health problems; please specify, e.g. drug or alcohol dependency, suicide, depression |  |

**8. Is there anything else about the health of yourself or any other family member that you would like to include?**

**Parent’s signature / Name** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social worker’s / witness’s signature** Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Source of information if parent is unable to provide it