STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families
Child Protective and Juvenile Justice Services

Form 1551
September 2016

CHILD/YOUTH MINIMAL FACTS SHEET

FOR USE WHEN A CHILD OR YOUTH IS REMOVED EXPARTE OR AFTERHOURS

Date Completed ☐ CPS ☐ JJS

CPS/JJS INVOLVEMENT (PLEASE INDICATE IF CHILD/YOUTH IS INVOLVED WITH OTHER BUREAU):

Yes ☐ No ☐ Worker's Name: _____ Telephone #: _____

REASON FOR PLACEMENT: _____

IDENTIFYING INFORMATION: **Name:** _____ Address: _____ City: _____ State: _____ Zip: _____	**DOB:** _____ **Gender:** Male ☐ Female ☐
Name of Parent 1: _____ ☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian Address: _____ Town: _____ State: _____ Zip: _____ Best Time For Visits _____	Best time to call: _____ Home Phone: _____ Cell Phone: _____ Message Phone: _____
Name of Parent 2: _____ ☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian Address: _____ Town: _____ State: _____ Zip: _____ Best Time For Visits _____	Best time to call: _____ Home Phone: _____ Cell Phone: _____ Message Phone: _____

Siblings (in or out of the home)

NAMES:	GENDER: M	GENDER: F	DOB:	IN HOUSEHOLD: YES	IN HOUSEHOLD: NO	CONTACT INFORMATION:
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	

Person(s) other than the parent(s) and sibling(s) to maintain contact with:

NAMES	RELATIONSHIP:	CONTACT INFORMATION:

EDUCATION & SCHOOL ☐ Home Schooled ☐ IEP/504

Current School: _____ **Current Grade:** _____

Contact Person: _____ Telephone Number: _____

PHYSICAL & MENTAL HEALTH

Name of Primary Care Provider (doctor)**:** _____ Phone Number: _____

Original – Placement Provider Copy - File

Address: _____

ALLERGIES (Food, Medication, Environment): _____

MEDICAL CONDITIONS: _____

MEDICATIONS: _____

Child/Youth's Significant Medical History: _____

Name of Dental Provider: _____ Phone Number: _____

Name of Therapist or Psychiatrist: _____ Phone Number: _____

DIAGNOSIS: _____

MEDICATIONS: _____

ANY SAFETY ISSUES (i.e. person(s) the parent feels are not safe to be around the child/youth, self-injurious behaviors etc.)

FIVE THINGS I WOULD LIKE THE FOSTER PARENT AND CASE WORKER TO KNOW ABOUT MY CHILD/YOUTH: (Examples: Who in the family is your child/youth closest to beside their parent(s) or sibling(s)? What does your child/youth like to do for fun or to relax? What will help your child/youth feel comfortable in the foster home? How does your child/youth stay in touch with extended family and school friends? Does your child/youth have pets?

Other important information that DCYF should have: