South Carolina
Department of Social Services

EDUCATION AND HEALTH PASSPORT

SC DSS complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

DSS Form 30245 (SEP 09)
South Carolina Department of Social Services
EDUCATION AND HEALTH PASSPORT

Instructions to Foster Parents

Please keep and maintain this Education and Health Passport while this child is in your care. Information should be updated regularly.

Items to be included in the pockets of the passport may include the child's:

- Educational grades
- School records
- Medicaid Card
- Social Security Card
- Birth Certificate
- Immunization Records

Take this Passport and your foster parent contract to all school meetings and medical/dental visits pertaining to the child. Remind teachers and school personnel, doctors, dentists, mental health care providers, vision care providers, and other health care providers to add or correct information on the form after each visit. Please share updated Passport with your caseworker at your next meeting. When the child leaves your care, this Passport must accompany the child.

If you have any questions, please contact your child’s Caseworker.

Thank you for keeping your foster child’s confidential education and medical records organized.

Child's Information

Child’s Name: ___________________________ Last First Middle

Name Also Known by: ______________________

DOB: ______/____/____ Age: ______ Gender: ☐ Male ☐ Female

Social Security Number: ________

Child's DSS Case Number: ____________________________

Medicaid Eligible? ________

Medicaid Number: ____________________________

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American ☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other

Child's Religious Preference: ____________________________

DSS Office Responsible for This Child: ____________________________

Street Address: ____________________________

Caseworker: ____________________________ Telephone: ____________________________

E-Mail: ____________________________ Fax: ____________________________

SC DSS Confidential Information

Date this page completed: _____ / _____ / _____
### Education Information

| **Home School Name:** (Before DSS foster care placement) |  |
| **Home School District:** (Before DSS foster care placement) |  |
| **Current School District:** |  |
| **School Name:** |  |
| **School Address:** |  |
| **School Phone:** |  |
| **Date of Enrollment:** |  |
| **End Date of Enrollment:** |  |
| **Current Grade:** |  |

#### Grade Level Performance:
- [ ] Above Grade
- [ ] At Grade
- [ ] Below Grade
- [ ] Special Education

**Comments:**

|  |
|  |

#### School Records:
(May include but is not limited to transcripts, attendance reports, psychological, and any records which are considered confidential.)
- [ ] Included
- [ ] Requested
- [ ] Not Requested

**Requested Date:** __/__/____

*(Records must be transferred within three days of request.)*

**Person contacted about record transfer:**

| Name: |  |
| Telephone: |  |

#### Immediate Education Needs:
(Briefly describe)

|  |
|  |

#### Special Education/Behavioral Issues?
- [ ] Yes
- [ ] No

**Briefly describe:**

|  |
|  |
Education Information (Cont'd)

Has child been determined eligible for special educational services?  
Individualized Education Plan (IEP):  □ Yes  □ No  
504 Accommodation:  □ Yes  □ No

Sensitive school information on file? (e.g., Disciplinary record, teacher's comments, etc.)  
□ Yes  □ No

Has DSS terminated parental rights?  
□ Yes  □ No  □ Unknown

Does DSS have educational rights for this child through a court order?  
□ Yes  □ No  □ Unknown

Is DSS providing independent living services for this child?  
□ Yes  □ No  □ Unknown

Are transition services being provided as part of the child's education program?  
□ Yes  □ No  □ Unknown

Awards and Achievements


Special Interests


Current Health Information

Allergies: (Description; include medication, foods, etc.)


Immediate Health Care Needs
Does child have health condition(s) requiring immediate attention?  
□ Yes  □ No  □ Unknown

Please specify what steps are being taken to determine the child's health condition:


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SC DSS Confidential Information

Date this page completed: ___ / ___ / ___

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Does the child have a life-threatening health condition?  □ Yes  □ No  □ Unknown
Does child have a communicable disease?  □ Yes  □ No  □ Unknown
Does child have asthma?  □ Yes  □ No  □ Unknown

Medication:

**Prescribed medications?**  □ Yes  □ No

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<tr>
<th>Name of Medication</th>
<th>Doctor's Name</th>
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Medication comments/instructions:

____________________________________

**Primary Health Concerns**
Description: (Primary health concerns, if any) ____________________________________________

Are immunizations up to date?  □ Yes  □ No
Is sensitive health information on file?  □ Yes  □ No

**Developmental/Functional Limitations**
- □ Visual Impairment
- □ Speech Impairment
- □ Special Diet Required
- □ Medical Equipment Required
- □ Developmentally Delayed
- □ Emotional Problem(s)
- □ Hearing Impairment
- □ Behavioral Problem(s)
- □ Neurological Impairment
- □ Other: (Describe) ____________________________
- □ Non-Ambulatory

**Physician or Current Health Service Provider(s) and Telephone Numbers**

Name: ____________________________________________ Telephone: ____________________________________________
- □ Medical
- □ Dentist
- □ Therapist
- □ Other

Name: ____________________________________________ Telephone: ____________________________________________
- □ Medical
- □ Dentist
- □ Therapist
- □ Other

Name: ____________________________________________ Telephone: ____________________________________________
- □ Medical
- □ Dentist
- □ Therapist
- □ Other

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*SC DSS Confidential Information*  
Date this page completed: _____ / _____ / _____
### Foster Parent Documentation

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<tr>
<th>Date</th>
<th>Description of Event</th>
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**SC DSS Confidential Information**

Date this page completed: ____ / ____ / ____
I have the right to:

1. Be treated as a normal and important human being.
2. Be cared for with love and affection.
3. Be provided adequate food, shelter and clothing.
4. Be heard and involved with the decisions of my life.
5. Be informed about and have involvement with my birth family and siblings, including the right to reject visits or contacts.
6. Complete information and direct answers to my questions about choices, services and decisions.
7. Reasonable access to my caseworker or a person in the agency who can make decisions on my behalf.
8. Express my opinion and have it treated respectfully.
9. Request the support and services that I need.
10. Individualized care and attention based on my unique skills and goals.
11. Ongoing contact with significant people in my life such as teachers, friends, my personal supports, and relatives.
12. Access to my case record to help me meet my goals.
13. Personal property, personal space, and my privacy.
14. Be notified of changes that affect my permanence, safety, stability, or well-being.
15. Practice my own religion.
16. Know what is expected of me in my foster placement.
17. Be cared for without regard to race, color, national origin, sex, religion or disability.
18. Caretakers who are interested in me and will support my involvement in social and school activities.
19. Have goals.
20. A plan for my future and support I need to accomplish it.

Written by GOALL (Go Out and Learn Life), the Youth Advisory Council, created to help the Department of Social Services improve its independent living program.

Important Telephone Numbers

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The department thanks the following organizations for their contributions in redesigning and updating the Education and Health Passport: GOALL, SC Foster Parents Association, SC Citizens Review Panel, and the Chafee Independent Living Program.