THE HEART MATTERS FOSTER FAMILY AGENCY

MEDICAL VISIT FORM

Date of Visit:_____

Child's Name:_____ **DOB:**_____ **Date of Placement:**_____

Resource Parent:_____ **Address:** _____ **Phone:**_____

Doctor's Name:_____ Phone:_____ **Office Stamp Here:**
Office Address: _____

Type of Visit: Please check the appropriate type of visit:

[ ] **CHDP/Initial Child Exam** [ ] **Sick Visit** [ ] **Specialized Visit**_____
[ ] **Follow-up visit** [ ] **Tx Ongoing**

[ ] **Routine Well Child:** Please indicate the child's visit age: _____ Month(s) or _____ Year(s) **Next WCE Due:** _____

Reason for Visit: _____ Physician
Type of Treatment Received: _____ Signature:_____

[ ] Yes [ ] No Is Child Ambulatory? [ ] Yes [ ] No Did Doctor Provide a Physical Exam?
[ ] Yes [ ] No Is Follow-up Action Required? List Instruction: _____

Results of Tests Done Today: Weight:_____Height:_____BP:_____HGB:_____Hearing:_____Vision:_____
Other Test Done Today/Results:_____ Date of T.B. Test: _____
List Any Immunizations Given Today:_____ Date of T.B. Test Read:_____
_____ Results: [ ] Negative [ ] Positive

Medications Prescribed Today: (Please List all Medication, prescribed and over the counter)

Medication Name	Strength/ Quantity	Instructions	Reason for Rx?	Is the Rx Available OTC?	As Needed	Start Date	End Date	# of Refills	Physician

Confidential case records pursuant to WIC 827 Distribution: County DCS/DCFS Social Worker, Foster Care Giver, Foster Agency Client Records.