

ON-GOING MEDICAL VISITS
Doctor, Emergency Room, Dentist and Eye Doctor

Note: Complete for all contacts with medical, dental and vision professionals including medical evaluations. Attach medical report if possible.

Child's name: _____ Date: _____

Foster parents: _____

Physician: _____ Phone: _____

Address of physician's office _____

Check one:

Office Call Scheduled Hospital Visit Emergency Room Medical Evaluation

Reason for visit: _____

Observations by physician: _____

Recommendations: (include prescriptions) _____

Regular Medications taken by child: _____

Date recommended of the next or follow-up visit: _____

Physician's Signature