



MEDICAL/DENTAL VISIT FORM (FOSTER CHILD)

CHILD'S NAME _____

DATE OF VISIT _____ ACCOMPANIED BY _____

Reason for visit:

Diagnosis and treatment given:

Regular medications taken by child:

Change in medications (if any):

Follow-up needed:

Next visit:

<i>PHYSICIAN/DENTIST (please circle one)</i>
NAME _____
ADDRESS _____
PHONE _____

Physician's Signature

Date

Rev 06/06