Child's Physician Visit Report

Please Print

FOSTER PARENT: PLEASE COMPLETE Prior to Appointment

Return this completed form to the Records Manager ASAP. THANK YOU!

Date of the Visit: _____ MM/DD/YYYY Foster Parent: _____

Type of Visit: ☐ CHDP ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ HEARING ☐ PSYCHIATRIC

☐ OTHER

Child's Name: _____ DOB: _____

Physician's Name: _____ Name of Office: _____

Physician's Address: _____

Phone: _____ Fax: _____

Reason for Appointment: _____

PHYSICIAN: PLEASE COMPLETE

PHYSICIAN- Comments/ Findings/ Diagnosis _____

Child's Height: _____ Child's Weight: _____.

Prescribed Treatment/ Medication as prescribed/ or Testing: _____

Follow-Up / Return / Referral _____

_____

Physician's Signature _____

cc: Office File Home File REV. 09/2022