Caring and serving since 1883®

Community Health and Counseling Services
Children's Services

HEALTH CARE VISIT FORM

The foster parent/staff member taking the client for the appointment is responsible for ensuring that the information contained in this document is accurate and complete and has been reviewed by the health care provider. The signature of the health care provider and the accompanying foster parent/staff member is required. **Please use the PHYSICAL HEALTH ASSESSMENT-MEDICAL HISTORY (CS #238a) and PHYSICAL HEALTH ASSESSMENT – EXAM- (CS #238b) for physicals.**

THIS SECTION TO BE COMPLETED BY FOSTER PARENT/STAFF

Client Name: _____ Case Number: _____ Date of Visit: _____

TYPE OF VISIT ☐ **Dental** ☐ **Eye** ☐ **Illness/Injury** ☐ **Medication Check** ☐ **Other** _____

REASON FOR THIS VISIT: _____

REPORTED ALLERGIES:_____

CURRENT MEDICATIONS:_____

NAME OF HEALH CARE PROVIDER: _____

ADDRESS:_____

PHONE:_____

_____ _____

Signature/title of foster parent/staff Date

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

NEW MEDICATION OR DOSAGE CHANGES

Medication Name	Dosage	Administration Instructions	Reason for Medication

DIAGNOSIS:_____

COMMENTS:_____

_____

RETURN VISIT NEEDED ☐ Yes ☐ No If Yes, date of visit _____

_____ _____ _____

Signature of Health Care Provider Title Date

Original -CHCS Client Record, Yellow - Foster Parent Photocopy - Guardian