**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 Meds. | Is the Med. Available over the counter? | As Needed | Start Date | End Date | # of Refills | Physician |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |