WASHOE COUNTY
DEPARTMENT OF SOCIAL SERVICES

Monthly Medical History Form for Children in Foster Care

For the Month of **January** For the Year of **2018**

Child's Name: Date Completed: Case No.:

Foster Parent: Social Worker:

MEDICAL INFORMATION: ☐ **No New Information**

Doctor: Appt. Date:

Diagnosis:

Medication(s):

DENTAL INFORMATION: ☐ **No New Information**

Doctor: Appt. Date:

Reason for Visit (check all that apply):

☐ Scheduled Check-up ☐ Cleaning ☐ Braces ☐ Cavity Filling ☐ Extractions ☐ Oral Surgery

☐ Other:

Medication(s):

COUNSELING INFORMATION: ☐ **No New Information**

Therapist:

Frequency of Appts:

Medication(s):

Prescribed by: Date of Last Med. Eval/Check:

Diagnosis:

SCHOOL INFORMATION: ☐ **No New Information**

School: Grade:

HOSPITALIZATION: ☐ **No New Information**

Where: Physician:

Admit Date: Discharge Date:

Reason:

Follow-Up Instruction:

ANY OTHER EXAMS/APPOINTMENTS: ☐ **No New Information**

When: Where: Why:

When: Where: Why:

FOR OFFICE USE ONLY:

☐ Input into UNITY Date Entered: Entered By: