



Respite Care
Foster Care

Health Care Provider Visit Record

Medical **Dental** **Vision**

(Please check appropriate box)

Name of Child: _____		Date of Birth: M ___ D ___ Y ___
Name of Foster Family: _____		Date of Visit: M ___ D ___ Y ___
Name of Provider: _____		
Provider Address: _____		
Reason for Visit: _____		
Outcome/Results (or Dx and Plan): _____		
Follow up/ Next Appointment	<input type="checkbox"/> None Needed	
	<input type="checkbox"/> Date: M ___ D ___ Y ___	Time: ___:___ AM / PM
Signatures		
Health Care Provider	Name: _____	
	Signature: _____	
Attending with Child		
Birth Parent	Name: _____	
	Signature: _____	
Foster Parent	Name: _____	
	Signature: _____	
Staff	Name: _____	
	Signature: _____	

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