G.A. FAMILY SERVICES
FOSTER CARE

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	☐ None Needed ☐ 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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