WASHOE COUNTY
DEPARTMENT OF SOCIAL SERVICES

Monthly Medical History Form for Children in Foster Care

For the Month of ______ For the Year of ______

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: ______