FOSTER CHILD’S HEALTH EVALUATION

Date:
Name of Child: Date of Birth: State ID: CHECK THE BOX THAT APPLIES:

Infant & Toddlers appointments:
☐ 2 week
☐ 2 month
☐ 4 month ☐ 6 month
☐ 9 month
☐ 12 month ☐ 15 month
☐ 18 month
☐ 24 month ☐ Other
(specify):

All other ages:
☐ 5 Annual ☐ Other
☐ Physical (specify):

Current assessment: (include surgeries, accidents, communicable diseases, chronic illnesses or handicapping problems):

_____________________________________________________________________

                     ______________________________________
_____________________________________________________________________

Medication: ☐ New ☐ Change: _______________________________________

dosage: _________________

Special instructions/comments/recommendations: (i.e. diets, exercises)

_____________________________________________________________________

                     ______________________________________
_____________________________________________________________________

_____________________________________________________________________
Allergies:
______________________________________________________________

______________________________________________________________

Immunizations: Date of completed primary or last booster:

Type: _________________ Date: _____________

Type: _________________ Date: _____________

If child is under 3 years of age, is a dental evaluation recommended?  Yes ☐ No ☐

Name of Health Professional: ____________________________________________

Phone: ____________________

A d d r e s s : __________________________________________________________

___________________________________________________________

__________________________

Health Care Professional Signature
Date