MEDICAL CARE VISIT FORM

Date of Visit:_____

This section is filled out by the Resource Parent: *This form is to be completed every time a child visits a health care provider.*

Child's Name:_____ Date of Birth:____/____/____

Resource Parent(s):_____ Address:_____

Home Phone:_____ Cell:_____

This section is filled out by the Doctor:

Doctor's Name:_____ Telephone Number:_____

Address:_____

Reason for the Visit:

□ Well Child Exam □ Sick Visit □ Specialized Visit □ Follow-Up Visit

Type of Treatment Received: _____

Is Follow-up Action Needed by Resource Parent? □ No □ Yes *(Please list instructions)*:_____

Weight: _____ **Height:** _____ **Blood Pressure:** _____

Hearing Screening Results: _____ **Vision Screening Results:**_____

Medication(s) Prescribed Today: (Please List all Medications PRN or Prescription, i.e vitamins, drops, etc.)

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS	REASON FOR DOSAGE i.e infection, temperature rash headache etc.	AVAIL. OTC? (N/Y)	PRN? (N/Y)	START DATE	END DATE	EXP. DATE	REFILL #

Any changes to current Medication(s):

□ No □ Yes *(If yes, please explain)* _____

Immunizations Given Today: □ No □ Yes *(please indicate below)*

□ DtaP Series _____ □ Hep Series _____ □ HPV _____ □ TB _____

□ Other Immunization(s) _____

Office Stamp Here:

Physician's Signature:_____

Confidential case records pursuant to WIC 827