

Ariel Clinical Services

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FOSTER CHILD'S HEALTH EVALUATION

Date: _____

Name of Child: _____ Date of Birth: _____

Reason for Visit: Annual Physical Other _____

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

Medication: New Change: _____ dosage: _____

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

Vision & Hearing screening completed? Yes No Referral needed for further testing? Yes No

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: _____

Address: _____

Health Care Professional Signature

Date