

Ariel Clinical Services

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FOSTER CHILD'S HEALTH EVALUATION

Date: _____

Child's Name: _____ Sex: _____ DOB: _____

Type of appointment (i.e. 2 month, 18 month, yearly physical) _____

Current assessment of Foster Child's health (include surgeries, accidents, communicable diseases, chronic illnesses or handicapping problems): _____

A vision and hearing screen completed? Yes No

Referral needed for further testing? Vision Hearing

Medication: New Change: _____ Dosage: _____

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

Allergies: _____

Immunizations: Date of completed primary or last booster:

Type: _____ Date: _____ Type: _____ Date: _____

Type: _____ Date: _____ Type: _____ Date: _____

If Tuberculin Test Give: Date: _____ Results: _____

If chest X-rayed: Date: _____ Results: _____

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

Name of Doctor (please print): _____

Address: _____ Phone: _____

Doctor's Signature: _____ Date: _____

Foster Child's Signature: _____ Date: _____