Medical, Dental, and Medication Record

Child's Name Birth Date Medical Plan Medicaid Number			Emergency Contact Name Address Phone Alternate Phone		
Date	Nature of Visit	Attending Physician	Prescribed Medication	Diagnosis/Recommendations/Notes	

For each visit to a physician, health center or dentist, enter date (month/day/year), complete name of the provider, prescribed medications, what was done, and recommendations. All evasive treatment must be prior approved by the guardian.

This form is to be given to the child's placement worker when requested and/or when the child leaves the foster home.

Name:							
					Date:		
Known allergies:							
	Date	Dosage, Dosage Times		Pharmacy Phone	Physician Name and Phone Number		
Name of Medication	Started	Times	Refill Number	Number	Phone Number	Comments	
						1	

All medication and/or dosage changes must be approved by the guardian.