Nevada Division of Child and Family Services Monthly Medical History Form for Foster Children

E-MAIL THIS FORM TO: fosterchildmedform@dcfs.nv.gov

("cc" child's caseworker on email)

Child's Nar	ne:						Date of	Birtl	h/Age:			\neg
	Foster Parent(s):					Date of Birth/Age: Date Completed:						
roster ratemets).								<u> </u>				
School	Info	rma	atio	on							☐ No New Information	n
School:	31110							Ad	dress:			
Grade:			Ex	tra. Act	tivities							
Type:								Phone:				
Individual Ed	. Plan:		Rep	ort Ca	rd: 🗆]		Fax	K :			
Learning Disa	Learning Disability:			E	Behavio	oral Issue : 🗆		Other:				
Date of IEP:	Pate of IEP:							Upcoming IEP:				
Comment:												
Please provide a copy of report card each semester											*	
Medica	al Inf	forn	nat	ion							☐ No New Information	n
Doctor:							Addres	s:				
Appt. Date:				Next A	Appt.:							
	Exam Type:						Phone:					
Physical:	l l	learin			Visio	n: 🗆	Screeni	ing /	EPSDT:		Date of Next:	
Sexual Abuse								Allergies:				
Prescribing Doctor:							Med. F	Med. Purpose:				
Medication Name:						Diagno	Diagnosis:					
Dosage/Frequency:						Follow	Follow up/Referral					
						Immunization	Receive	d				
☐ Ch☐ Dip☐ Te☐ DT☐ Inf☐ Me	☐ Allergy ☐ Chicken Pox ☐ Diphtheria/Tetanus/Pertussis ☐ Tetanus ☐ DTP Booster ☐ Influenza ☐ Mosslos/Mumps/Pubolla					Hepatitis A Hepatitis B HIBI HIB2 HIB3	ubella/chi	cken	☐ HPV ☐ H1N1 ☐ PPLIOOPV/IPV1 ☐ PPLIOOPV/IPV2 ☐ PPLIOOPV/IPV3 ☐ TDAP ☐ TOTA TEQ ☐ Other:			
Medical Information ☐ No New Information Doctor: Address:										<u>n</u>		
Appt. Date:		Next Appt.:										

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	Ex	kam Type:		Phone:						
Physical:		/ision: \square		Screening /EPSDT: Date of Next:						
Sexual Abuse:		Other:		Allergies:						
Prescribing Do	ctor:				Med. Purpose:					
Medication Na	ame:			Diagnosis:	·					
Dosage/Frequ	ency:			Follow up/F	Referral					
<u> </u>	· ·									
Immunization Received										
☐ Alle	rav		☐ PRQD		☐ HPV	,				
	cken Pox		(measles/mumps	/rubella/chicken	□ H1N1					
		anus/Pertussis	pox)		☐ PPLIOOPV/IPV1					
☐ Teta		31143/1 61 (43313	☐ Hepatitis A			□ PPLIOOPV/IPV2				
	Booster		☐ Hepatitis B			IOOPV/IPV3				
□ Infl			☐ HIBI		□ TDAP					
		nps/Rubella	☐ HIB2		□ тот					
	man Mea	•	☐ HIB3		☐ Othe					
			☐ HIB4							
Dental I	Inform	ation				☐ No New Information				
Doctor:	111101111	ation		Address:		□ No New Illiormation				
		Novt Apr	n+ ·	Address:						
Appt. Date:	Ev	Next App kam Type:)t.:	Phone:						
Cleaning:	Filling		Braces: \square	Fax:						
Extractions:		Other:	oraces. \Box	Follow up:						
Prescribing Do		Other.		Med. Purp	ose.					
Medication Na				Comment:	030.					
Dosage/Frequ										
Dosage/Trequ	Cricy.									
Counseling Information										
Therapist:				Address:						
Appt. Date:		Next A	opt.:							
	Asse	ssment Type:		Phone:						
			Counseling:	Fax:						
Other:			Frequency of A							
Last Mental Ev			Т	reatment Goals						
Prescribing Do	ctor:			Med. Purp	Med. Purpose:					

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Medication N	Name:				(Com	ment:						
Dosage/Freq													
Hospitalization/Urgent Care Information							□ No New						
Physician:					Α.	Addr	ess:						
Date:	_		Discharge:										
Hospital Nan	ne:				P	hon	ne:						
Time In:			Surgery:		F	ollo	w Up						
Reason:			lı	Instructions:									
Attending Ph	ysician:					∕led.	. Purpose						
Medication N	Name:			Diagnosis:									
Dosage/Freq	uency:					Comment:							
		xam/A	ppointr	nent						No New Information			
Adviser/Doctor						Address:							
Appointmer Date:	nt		Next Appointm										
Appointment Type:							Phone:						
WIC: □	Medicai	d: 🗆	Resourc	es: 🗆	Other	:		Fax:					
Medication N	Name:						Dosage/	Frequenc	y:				
Comment:													