

**WASHOE COUNTY  
DEPARTMENT OF SOCIAL SERVICES**

Monthly Medical History Form for Children in Foster Care  
For the Month of  For the Year of

Child's Name:  Date Completed:  Case No.:   
Foster Parent:  Social Worker:

**MEDICAL INFORMATION:**

**No New Information**

Doctor:  Appt. Date:

Diagnosis:

Medication(s):

**DENTAL INFORMATION:**

**No New Information**

Doctor:  Appt. Date:

Reason for Visit (check all that apply):

Scheduled Check-up     Cleaning     Braces     Cavity Filling     Extractions     Oral Surgery

Other:

Medication(s):

**COUNSELING INFORMATION:**

**No New Information**

Therapist:

Frequency of Appts:

Medication(s):

Prescribed by:  Date of Last Med. Eval/Check:

Diagnosis:

**SCHOOL INFORMATION:**

**No New Information**

School:  Grade:

**HOSPITALIZATION:**

**No New Information**

Where:  Physician:

Admit Date:  Discharge Date:

Reason:

Follow-Up Instruction:

**ANY OTHER EXAMS/APPOINTMENTS:**

**No New Information**

When:  Where:  Why:

When:  Where:  Why:

**FOR OFFICE USE ONLY:**

Input into UNITY

Date Entered:

Entered By: