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

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name: |  | Date of Birth/Age: |  |
| Foster Parent(s): | | Date Completed: |  |
|  | | | |

**School Information ☐ No New Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| School: |  | | | | | Address: |  | |
| Grade: |  | | Extra. Activities | |  |
| Type: | | | | | | Phone: |  | |
| Individual Ed. Plan: ☐ | | | Report Card: ☐ | | | Fax: |  | |
| Learning Disability: ☐ | | | | Behavioral Issue : ☐ | | Other: | | |
| Date of IEP: | |  | | | | Upcoming IEP: | |  |
| Comment: | |  | | | | | | |

**\*Please provide a copy of report card each semester\* \*Please provide a copy of IEP annually\***

**Medical Information ☐ No New Information**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Doctor: |  | | | | | | Address: |  | |
| Appt. Date: |  | | | Next Appt.: | |  |
| Exam Type: | | | | | | | Phone: |  | |
| Physical: ☐ | | Hearing: ☐ | | | Vision: ☐ | | Screening /EPSDT: ☐ Date of Next: | | |
| Sexual Abuse: ☐ | | | Other: | | | | Allergies: | |  |
| Prescribing Doctor: | | |  | | | | Med. Purpose: | |  |
| Medication Name: | | |  | | | | Diagnosis: | |  |
| Dosage/Frequency: | | |  | | | | Follow up/Referral | |  |

|  |  |  |
| --- | --- | --- |
| **Immunization Received** | | |
| ☐ Allergy  ☐ Chicken Pox  ☐Diphtheria/Tetanus/Pertussis  ☐ Tetanus  ☐ DTP Booster  ☐ Influenza  ☐ Measles/Mumps/Rubella  ☐ German Measles | ☐ PRQD (measles/mumps/rubella/chicken pox)  ☐ Hepatitis A  ☐ Hepatitis B  ☐ HIBI  ☐ HIB2  ☐ HIB3  ☐ HIB4 | ☐ HPV  ☐ H1N1  ☐ PPLIOOPV/IPV1  ☐ PPLIOOPV/IPV2  ☐ PPLIOOPV/IPV3  ☐ TDAP  ☐ TOTA TEQ  ☐ Other: |

**Medical Information ☐ No New Information**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Doctor: |  | | | | | | Address: |  | |
| Appt. Date: |  | | | Next Appt.: | |  |
| Exam Type: | | | | | | | Phone: |  | |
| Physical: ☐ | | Hearing: ☐ | | | Vision: ☐ | | Screening /EPSDT: ☐ Date of Next: | | |
| Sexual Abuse: ☐ | | | Other: | | | | Allergies: | |  |
| Prescribing Doctor: | | |  | | | | Med. Purpose: | |  |
| Medication Name: | | |  | | | | Diagnosis: | |  |
| Dosage/Frequency: | | |  | | | | Follow up/Referral | |  |

|  |  |  |
| --- | --- | --- |
| **Immunization Received** | | |
| ☐ Allergy  ☐ Chicken Pox  ☐Diphtheria/Tetanus/Pertussis  ☐ Tetanus  ☐ DTP Booster  ☐ Influenza  ☐ Measles/Mumps/Rubella  ☐ German Measles | ☐ PRQD (measles/mumps/rubella/chicken pox)  ☐ Hepatitis A  ☐ Hepatitis B  ☐ HIBI  ☐ HIB2  ☐ HIB3  ☐ HIB4 | ☐ HPV  ☐ H1N1  ☐ PPLIOOPV/IPV1  ☐ PPLIOOPV/IPV2  ☐ PPLIOOPV/IPV3  ☐ TDAP  ☐ TOTA TEQ  ☐ Other: |

**Dental Information ☐ No New Information**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Doctor: |  | | | | | | Address: | |  | | |
| Appt. Date: |  | | | Next Appt.: | |  |
| Exam Type: | | | | | | | Phone: | |  | | |
| Cleaning: ☐ | | Fillings: ☐ | | | Braces: ☐ | | Fax: | |  | | |
| Extractions: ☐ | | | Other: | | | | | Follow up: | |  | |
| Prescribing Doctor: | | |  | | | | Med. Purpose: | | | |  |
| Medication Name: | | |  | | | | Comment: | | | |  |
| Dosage/Frequency: | | |  | | | |

**Counseling Information ☐ No New Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Therapist: |  | | | | | | | | Address: |  | | |
| Appt. Date: |  | | | | Next Appt.: | |  | |
| Assessment Type: | | | | | | | | | Phone: |  | | |
| Psychological: ☐ | | Psychiatric: ☐ | | | | Counseling: ☐ | | | Fax: |  | | |
| Other: | | | | | | Frequency of Appt.: | | | | | | |
| Last Mental Evaluation: | | | |  | | | | Treatment Goals: | | |  | |
| Prescribing Doctor: | | |  | | | | | | Med. Purpose: | | |  |
| Medication Name: | | |  | | | | | | Comment: | | |  |
| Dosage/Frequency: | | |  | | | | | |

**Hospitalization/Urgent Care ☐ No New Information**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Physician: |  | | | | | | Address: |  | |
| Date: |  | | | Discharge: | |  |
| Hospital Name: | |  | | | | | Phone: |  | |
| Time In: | |  | | Surgery: |  | | Follow Up Instructions: | |  |
| Reason: | | |  | | | |
| Attending Physician: | | |  | | | | Med. Purpose: | |  |
| Medication Name: | | |  | | | | Diagnosis: | |  |
| Dosage/Frequency: | | |  | | | | Comment: | |  |

**Any Other Exam/Appointment ☐ No New Information**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Adviser/Doctor | |  | | | | | | Address: | |  | |
| Appointment  Date: | |  | | Next Appointment: | |  | |
| Appointment Type: | | | | | | | | Phone: | |  | |
| WIC: ☐ | Medicaid: ☐ | | | | Resources: ☐ | | Other: | | Fax: | |  |
| Medication Name: | | |  | | | | | Dosage/Frequency: | | |  |
| Comment: | | |  | | | | | | | | |