**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: |  |