Foster Family Agency
"Our Children...
Our Communities...
Our Legacy..."

HEALTH CARE CONFIRMATION

Child's Name: ____________________________ DOB: __________________________________

The above-mentioned child was in our office on (Date) ________________________________

For the following procedure(s):
[ ] CHDP
[ ] Medical
[ ] Vision
[ ] Other: ________________

Height: ___________________

Weight: __________________

Hemoglobin: ____________

Reason for Visit:

____

____

Provider's Comments/Findings/Diagnosis:

____

____

Immunizations Given:

____

____

Prescribed Treatment/Medication/Testing:

____

____

Follow-up/Referrals:

____

____

Name of Provider: ______________________________ Phone: ____________________
Address: ____
____
____

Signature: ____

Please return this form to the resource parent upon completion.

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