



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

## SPECIALIZED HEALTH CARE NEEDS TRAINING

The health care need for the child is:

\_\_\_\_\_ *(ie. tubing oxygen, diabetes, premie, etc.)*

**Child's Name** \_\_\_\_\_

**Resource Parent's Name** \_\_\_\_\_

The resource parents were trained in the following procedures *(please list)*:


Date of Training: \_\_\_\_\_

Length of Training *(in hours or portion thereof)*: \_\_\_\_\_

\_\_\_\_\_  
 Health Care Provider Print

\_\_\_\_\_  
 Health Care Provider Credentials

\_\_\_\_\_  
 Health Care Provider Signature

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