



### Physician/Dentist Visit Form

*This form should be completed by the parent/caregiver accompanying the child to the appointment. After completion it should be sent with your weekly notes.*

- Primary Care Physician**
- Dentist**
- Eye Doctor**
- Specialist**

**Visit Date:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **A#:** \_\_\_\_\_

**Doctor's Name:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

\_\_\_\_\_

**Purpose of Visit:**

\_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_

**Recommendations:**

\_\_\_\_\_

**Medication(s) Prescribed?**  No  Yes (If yes list medication(s) prescribed)

\_\_\_\_\_

**Follow up visit?**  No  Yes – If yes, date: \_\_\_\_\_

**Know Allergies?**

\_\_\_\_\_

**Immunizations Current?**  No  Yes – date of last series: \_\_\_\_\_

\_\_\_\_\_  
Foster Parent Signature

\_\_\_\_\_  
Date