

MONTHLY HEALTH ACTIVITY SHEET

Case # _____

Please Submit With You Monthly Notes If Any
Health Related Activities Occurred During The Month

Child's Name: _____ Case Workers Name: _____

Foster Parent/ Provider Name: _____

Treatment Type: Dental Medical Mental Vision Specialist

Full Name & Address of -Physician/ Hospital/ Provider: (Use as many lines as needed for provider)	Date of Appointment/s:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Type of Service:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> 30 day Healthcek | <input type="checkbox"/> 60 day Healthcek | <input type="checkbox"/> Annual Healthcek | <input type="checkbox"/> Illness |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Follow-up | <input type="checkbox"/> Non- Annual Physical | <input type="checkbox"/> Lab/ Testing |
| <input type="checkbox"/> Cleaning/ Exam | <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Mental Assessment | <input type="checkbox"/> Diagnostic |
| <input type="checkbox"/> Eye Glasses/contacts | <input type="checkbox"/> Procedure/ Surgery | <input type="checkbox"/> Immunization | <input type="checkbox"/> Pre- Natal |
| <input type="checkbox"/> Other: Please specify _____ | | | |

Further Description if needed: _____

List Type/s -Illness, injury, testing, immunization (list each immunization separately) & What Dr. did. Results of appt.:

Does the child have to go back for a follow-up visit? Yes No

If yes, Date of follow-up appointment/s: _____

Will transportation be needed? Yes No