MONTHLY HEALTH ACTIVITY SHEET

Case Number _____

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

Child's Name: _____ Case Worker: _____

Foster Parent/ Provider Name:_____

Treatment Type: **Dental** ☐ **Medical** ☐ **Mental** ☐ **Specialist** ☐ **Vision** ☐

Name, Address & Phone of Physician/ Hospital/ Provider:
(Use as many lines as needed)

Date of Appointment/s:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Type of Service:

☐ 30 day Healthchek	☐ 60 day Healthchek	☐ Annual Healthchek	☐ Illness
☐ Injury	☐ Follow-up	☐ Non- Annual Physical	☐ Lab/ Testing
☐ Cleaning/ Exam	☐ Orthodontist	☐ Mental Assessment	☐ Diagnostic
☐ Eye Glasses/contacts	☐ Procedure/ Surgery	☐ Immunization	☐ Pre- Natal

☐ Other: Please specify _____

Further Description if needed: _____

List Why child went to Doctor –(Illness, injury, immunization- ***list each immunization separately)*** &
Results of Appointment (Diagnosis, Medications, *what doctor did*)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

Foster Parent/ Providers' Name: _____ Date: _____

Social Workers' Name: _____ Date: _____

Columbiana County Department of Job & Family Services
Children Services
7989 Dickey Dr. Suite 2
Lisbon, OH 44432
(330) 420-6600 FAX (330) 424-0931