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 ☐ Other Specify_____

Name, Address & Phone of Physician/ Hospital/ Provider:

(Please print clearly / use as many lines as needed to provide all above information for each appointment)

Date of Appointment/s:

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

Type of Service:

☐ 30 day Health check	☐ 60 day Health check	☐ Annual Health check	☐ 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

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