**Wesley Family Services Foster Care**

 **Dental/Medical Form**

*To be completed by the treating medical or dental personnel*

*at the time of the child’s appointment*

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for appointment

|  |
| --- |
|  |

Diagnosis

|  |
| --- |
|  |

Course of Treatment

|  |
| --- |
|  |

Follow-up Treatment

|  |
| --- |
|  |

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Return completed form to the child’s assigned Foster Care Coordinator*

Form No: PH2

**Revised 11/7/14amg**