HEALTH EXAM FORM

☐ Health ☐ Dental ☐ Vision

DATE OF VISIT: _____

Placing County: _____

YOUTH'S NAME: _____ **DOB:** _____

RESOURCE PARENT(S): _____ **N/A:** _____

YFP SW/CM: _____ **CFS SW:** _____

PROVIDER NAME: _____

ADDRESS: _____

PHONE: _____

REASON FOR THE VISIT (i.e. illness, injury, hearing exam, psychiatric eval. or treatment, medication adjustment or eval., illness follow-up etc.)

_____

PROVIDER'S COMMENTS//FINDINGS:

_____

_____

PRESCRIBED TREATMENT//MEDICATION:

_____

_____

If patient is currently prescribed or taking over-the-counter medication (including psychotropic):

- ○ This patient is able to self-administer all medication(s)
- ○ This patient must have a care provider administer all medication(s)
- ○ Not applicable

PLANNED FOLLOW-UP//RETURN//REFERRAL:

_____

DR/AUTHORIZED REPRESENTATIVE: _____

(Signature)

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