Nevada Division of Child and Family Services
Monthly Medical History Form for Foster Children

E-MAIL THIS FORM TO: fosterchildmedform@dcfs.nv.gov
(“cc” child’s caseworker on email)

Child’s Name:		Date of Birth/Age:	
Foster Parent(s):		Date Completed:	

School Information

☐ **No New Information**

School:				Address:	
Grade:		Extra. Activities			
Type:				Phone:	
Individual Ed. Plan: ☐		Report Card: ☐		Fax:	
Learning Disability: ☐		Behavioral Issue : ☐		Other:	
Date of IEP:				Upcoming IEP:	
Comment:					

Please provide a copy of report card each semester ***Please provide a copy of IEP annually***

Medical Information

☐ **No New Information**

Doctor:				Address:	
Appt. Date:		Next Appt.:			
Exam Type:				Phone:	
Physical: ☐	Hearing: ☐	Vision: ☐		Screening /EPSDT: ☐	Date of Next:
Sexual Abuse: ☐	Other:			Allergies:	
Prescribing Doctor:				Med. Purpose:	
Medication Name:				Diagnosis:	
Dosage/Frequency:				Follow up/Referral	

Immunization Received		
☐ Allergy ☐ Chicken Pox ☐Diphtheria/Tetanus/Pertussis ☐ Tetanus ☐ DTP Booster ☐ Influenza ☐ Measles/Mumps/Rubella ☐ German Measles	☐ PRQD (measles/mumps/rubella/chicken pox) ☐ Hepatitis A ☐ Hepatitis B ☐ HIBI ☐ HIB2 ☐ HIB3 ☐ HIB4	☐ HPV ☐ H1N1 ☐ PPLIOOPV/IPV1 ☐ PPLIOOPV/IPV2 ☐ PPLIOOPV/IPV3 ☐ TDAP ☐ TOTA TEQ ☐ Other:

Medical Information

☐ **No New Information**

Doctor:				Address:	
Appt. Date:		Next Appt.:			

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Exam Type:			Phone:	
Physical: ☐	Hearing: ☐	Vision: ☐	Screening /EPSDT: ☐	Date of Next:
Sexual Abuse: ☐	Other:		Allergies:	
Prescribing Doctor:			Med. Purpose:	
Medication Name:			Diagnosis:	
Dosage/Frequency:			Follow up/Referral	

Immunization Received		
☐ Allergy ☐ Chicken Pox ☐ Diphtheria/Tetanus/Pertussis ☐ Tetanus ☐ DTP Booster ☐ Influenza ☐ Measles/Mumps/Rubella ☐ German Measles	☐ PRQD (measles/mumps/rubella/chicken pox) ☐ Hepatitis A ☐ Hepatitis B ☐ HIBI ☐ HIB2 ☐ HIB3 ☐ HIB4	☐ HPV ☐ H1N1 ☐ PPLIOOPV/IPV1 ☐ PPLIOOPV/IPV2 ☐ PPLIOOPV/IPV3 ☐ TDAP ☐ TOTA TEQ ☐ Other:

Dental Information

☐ **No New Information**

Doctor:				Address:	
Appt. Date:		Next Appt.:			
Exam Type:				Phone:	
Cleaning: ☐	Fillings: ☐	Braces: ☐		Fax:	
Extractions: ☐	Other:			Follow up:	
Prescribing Doctor:				Med. Purpose:	
Medication Name:				Comment:	
Dosage/Frequency:					

Counseling Information

☐ **No New Information**

Therapist:				Address:	
Appt. Date:		Next Appt.:			
Assessment Type:				Phone:	
Psychological: ☐	Psychiatric: ☐	Counseling: ☐		Fax:	
Other:		Frequency of Appt.:			
Last Mental Evaluation:		Treatment Goals:			
Prescribing Doctor:				Med. Purpose:	

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Medication Name:		Comment:	
Dosage/Frequency:			

Hospitalization/Urgent Care Information

☐ **No New**

Physician:				Address:	
Date:		Discharge:			
Hospital Name:				Phone:	
Time In:		Surgery:		Follow Up Instructions:	
Reason:					
Attending Physician:				Med. Purpose:	
Medication Name:				Diagnosis:	
Dosage/Frequency:				Comment:	

Any Other Exam/Appointment

☐ **No New Information**

Adviser/Doctor				Address:		
Appointment Date:		Next Appointment:				
Appointment Type:				Phone:		
WIC: ☐	Medicaid: ☐	Resources: ☐	Other:		Fax:	
Medication Name:				Dosage/Frequency:		
Comment:						