590 Antelope Blvd.
P.O. Box 950
Red Bluff, Ca. 96080
(530) 528-2938
(530) 528-8034 FAX

NOTE TO PARENT:
Please have this form filled out for EVERY doctor and/or dentist office visit.

HEALTH PROVIDER CONTACT FORM

Child's Name: _____ **DOB:** _____

Foster Parent(s): _____

Agency Social Worker: _____ **County Social Worker:** _____

Provider's Name: _____ **Provider's Phone:** _____

Provider's Address: _____

Note to Provider: Please fill out the information below with SPECIFIC data regarding the child's visit.

Date of Visit: _____ **Ht. Today:** _____ **Wt. Today:** _____

REASON FOR VISIT: (i.e., CHDP, illness, injury, dental exam or treatment, vision or hearing exam, psychiatric evaulation or treatment, medication adjustment or evaluation, etc.)

_____

_____

_____

PROVIDER'S DIAGNOSIS, COMMENTS, FINDINGS, ETC:

_____

_____

_____

IMMUNIZATIONS GIVEN:

☐ **Dtap** ☐**Hep B** ☐**Hib** ☐**Pneum** ☐**Polio** ☐**MMR** ☐**VZV** ☐**Hep A** ☐**Other** _____

PRESCRIBED TREATMENT, MEDICATION, TESTING, ETC:

_____

_____

_____

PLANNED FOLLOW UP CARE, RETURN, AND/OR REFERRAL:

_____

_____

_____

PROVIDER'S SIGNATURE: _____ **DATE:** _____