

FOSTER FAMILY / RESIDENTIAL TREATMENT
100 Poplar Avenue, MODESTO, CA 95354
(209) 491-0872

MEDICAL SUMMARY

This form must be filled out in its entirety and accompany the child to the appointment. Please bring Medi-Cal/Insurance Card.
Completed form should be placed in the child's record under Medical section.

I. REFERRAL INFORMATION (to be completed by staff/foster parent)

Name of Child: _____

Foster Parent: _____ Insurance: _____

Date/Time: _____ Height: _____ Weight: _____

Type of Contact:	Medical	Dental
	Vision	Emergency/Urgent Care

Name of Physician: _____ Phone Number _____

Address: _____

Reason for Visit/Symptoms: _____

Current Medications/Dosage: _____

Allergies: _____

II. PHYSICIAN STATEMENT (to be completed by medical provider)

Diagnosis: _____

Treatment: _____

Prescriptions: _____

Follow-up: _____

Signature: _____

Date: _____