

MEDICAL REPORT FORM

MEDICAL FORM FOR CHILDREN CURRENTLY IN THE HOME

| <u>I, </u> | , hereby give my authorization for my Physician to | |
|--|--|--|
| release the following information to the Agency Named above: | | |
| Signature of Parent: | Date: | |
| Name of Child: | DOB: | |
| TO BE COMPLETED BY THE PHYSICICAN | <u>l:</u> | |
| Is this child regularly treated by you? [|] Yes [] No | |
| If Yes, what medical services have you | provided? | |
| | | |
| | | |
| | | |
| Does this child have any physical or emo | otional disorders or any major medical concerns? | |
|] Yes [] No | | |
| f Yes, please explain? | | |
| | | |
| | | |
| | | |
| mmunizations Up to Date: [] Yes [|] No | |
| f No, what is needed: | | |

| Attach Immunization Records to this form. | | |
|---|-----------------------|--|
| Physician's Printed Name | Physician's License # | |
| Physicians Signature | | |
| Facility Name: | | |
| Address: | | |
| City: | State: | |
| Phone: | Fax: | |
| Office Stamp: | | |
| Date: | | |