3001 Market St., Camp Hill, PA 17011
Tel. 717.412.0772 or 800.445.2444 Fax 717.412.0775
CommonSenseAdoption.org

Adoption & Foster Care SERVICES

DOCTOR'S VISIT FOR FOSTER CARE

Date of Visit:___________________ **Name of Child:**____________________________________

Height:_________________________ Weight:__________________

Check One: ☐ Well Child Exam ☐ Sick Visit ☐ Follow-up Visit ☐ Emergency ☐ Other

Review of the child's history: ____

____

Physical Examination of the child: ____

____

____

Laboratory or diagnostic tests as indicated by the examining physician, including those required to detect communicable disease: ____

____

____

(*PLEASE ATTACH A COPY OF THE LAB WORK IF APPLICABLE*)

Immediate medical attention required: ____

____

____

____ ____________________________________
Signature of Doctor Printed Name of Doctor

____
Address

____
Phone

Foster Care Schedule of Well Child visits with a licensed physician

Age	Frequency
Birth through six months	Once per six weeks
Seven months through 23 months	Once per three months
23 months and older	Once per year