Healthy Foster Care America

HEALTH SUMMARY FORM

Medical Record No. or Stamp

Date:

Child's Name: _____

Date of birth: _____ Date into FC: _____

Current health conditions/issues (acute and chronic):

_____

_____

_____

Medications:

_____

_____

_____

Other concerns (home, school, community): _____

_____

_____

Immunizations (administered or provided):

_____

_____

_____

Allergies:

_____

_____

_____

Medical Referrals			
Where/Who	When	Contact Info	Addressing which issue?

Services Recommended		
Provider	Contact Info	Addressing which need?

Treatment plans: _____

_____

_____

Health care facility: _____

_____

Address: _____

_____

Clinician: _____

Phone: _____

Fax: _____

Additional Comments

Next appointment here:

www.aap.org/fostercare

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™