CHILD’S MEDICAL VISIT FORM

Date of Visit: ______  Child’s Name/DOB: _______________  Household #: _______

Type of Visit:
( ___Initial Physical) ( ___Well Baby at age _____) ( ___Annual Physical)( ___Other ______)

Name of Physician:_________________________________________________________

Address of Physician:_____________________________________________________

Diagnosis and Treatment given:

Regular Medications Taken by Child/New Prescriptions:

☐ Vision Checked
  ▪ Comments/Concerns:
  ▪ Date of next recommended vision check: ______________________

☐ Hearing Checked
  ▪ Comments/Concerns:
  ▪ Date of next recommended hearing check: ______________________

Physician Signature: ___________________________________ Date: ____________
CHILD’S DENTAL VISIT FORM

Date of Visit: __________ Child’s Name/DOB: ________________ Household #: ____________

Type of visit: (___ Initial) (___ 6-month) (___ Other: ____________________)

Name of Dentist: ________________________________________________________________

Address of Dentist: _____________________________________________________________

Diagnosis and Treatment Provided/Follow up Dental Work:

Dentist Signature: _____________________________________________________________ Date: __________________________