MARIN COUNTY HEALTH AND HUMAN SERVICES
HEALTH AND DENTAL CONTACT FORM

This form is to be completed for EVERY medical or dental visit.
When it has been completed, please give to the social worker/probation officer or return by mail or fax.

To be completed by Resource Family:

DATE OF VISIT: _____

Child's Name	DOB
Child Welfare Worker/Probation Officer	Phone
Resource Family Home	Phone
Name of Primary Physician/Health Care Provider/Agency	Phone

To be completed by Physician/Health Care Provider:

Type Of Visit MEDICAL: CHDP ☐ Well Child ☐ Sick ☐ F/U ☐ Specialist ☐
DENTAL: Preventative ☐ Treatment ☐

Findings/Labs HCT/Hgb _____ Height _____ (____%) Weight _____ (____%) Head circ. _____ (____%)
Vision Left _____ Right _____ Hearing: Left _____ Right _____

Allergies ☐ Food: _____ ☐ Insects: _____
☐ Environmental: _____ ☐ Medications: _____

Current Health Problem/Diagnoses: *(Communicable: ☐ Yes ☐ No)*

New Medications/Treatments:

Ongoing Medications/Treatments:

Immunizations (# in series)

Next immunization due:

Developmental Assessment: Normal ☐ Abnormal ☐ *(explain)*

Referrals: *(ex.: specialists, mental health, dental, CCS, speech & hearing, IEP)*

FOLLOW UP APPOINTMENTS:

Physician/Health Care Provider Name (**PLEASE PRINT**)	Signature	Date
Address		Phone

Resource Family-mail or FAX to: Foster Care Public Health Nurse ● 3250 Kerner Blvd. ● San Rafael, CA 94901 ● (415) 473-2200 ● FAX (415) 473-7162
WHITE COPY:-Social Services ***CANARY COPY: Resource Family Home*** ***PINK COPY: Health Care Provider***