

**KENOSHA HUMAN DEVELOPMENT SERVICES, INC.  
SPECIALIZED FOSTER CARE**

**Physician/Dentist Visit Form**

**To Be Filled Out By Foster Parent:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Accompanied by: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Parent or Responsible Agency Notified:  Yes  No  Not Necessary

**To Be Filled Out By Physician/Dentist:**

Diagnosis:

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Treatment and Medication Prescribed:

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List Any Restrictions (i.e. School, diet, activities, etc.) and/or Complications to Watch for:

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Comments:

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Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_