NORTHERN VIRGINIA FAMILY SERVICE
THERAPEUTIC FOSTER CARE PROGRAM

REPORT OF MEDICAL VISIT

Name of Child: _____

Date of Birth: _____ **Date of Medical Visit**: _____

Physician Name:_____ **Phone**: _____

Address:_____

Reason for Visit:

Physician's Treatment and Recommendations:

Medications prescribed? _____ Yes _____ No
If yes, name of medication prescribed.

_____

Follow-up visit needed? _____ Yes _____ No If yes, Date:_____

_____ _____
Signature of Physician or Nurse Practitioner **Date**