MEDICAL, DENTAL, AND THERAPY
APPOINTMENTS

MONTHLY REPORT MUST BE RECEIVED IN THE OFFICE BY THE 10TH OF EACH MONTH

_____ _____

Child's Name Month Year

MEDICAL AND DENTAL INFORMATION

(Please list all appointments whether it was dental, medical, or vision)

Date	Name of Doctor/Dentist/Medical Center ***very important***	Reason for visit	Follow-up Yes/no

Please have HEALTH PROVIDER CONTACT form filled out for each visit and return with monthly report!

Counseling: _____

Therapists Name

Counseling Dates:
