

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:
