Documentation of Health Intervention

Child's Name: _____ DOB: _____

Provider Name: _____ Specialty: _____

Address: _____ Phone: _____

_____ Apt. Date: _____

_____

Type of Appointment:

☐ Medical ☐ Dental ☐ Optical ☐ Psychological ☐ Therapy

- Reason for Appointment:

_____

_____

_____

- Provider Instruction/Feedback:

_____

_____

_____

- New Medication Orders Issued/ Medication Orders Discontinued: ☐ N/A

(Must include dosage and administration instructions)

_____

_____

_____

- Reason For Medication Changes/Side Effects for which to Monitor: ☐ N/A

_____

_____

_____

- Follow-Up Recommendations/Future Appointments:

_____

_____

_____

_____ _____

Copies to: Child's File

Provider Signature

Date

Copies to: Child's File