



**MEDICAL REPORT**

To be completed by the Doctor/Dentist at every appointment

**ATTENTION Doctor or Dentist Offices:**

**Please fax completed form to Family Link: 512-233-6473 Ph: 512-233-6464**

**Name of Child:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Date of Visit:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Check All That Apply:**

Annual Medical Exam: MUST INCLUDE TB TEST/SCREEN, HEARING & VISION SCREENING

- TB Screening: date given: \_\_\_\_\_ (required annually)
- TB Test: date given: \_\_\_\_\_ date read: \_\_\_\_\_  Pos  Neg  
(required for a 1 year old and when child comes into care)
- Vision Screening: \_\_\_\_\_  Norm  Abn (Children over 4 need Eye Exam)
- Hearing Screening: \_\_\_\_\_  Norm  Abn (Children over 4 need Hearing Exam)

Eye Exam \_\_\_\_\_ / \_\_\_\_\_  Hearing Exam Rt: \_\_\_\_\_ /Left: \_\_\_\_\_

Dental Exam  Follow-up Visit \_\_\_\_\_  Emergency

Any Immunizations or boosters given today?  Yes  No

If Yes, Specify and attach immunization form: \_\_\_\_\_

Other \_\_\_\_\_ Diagnosis if ill: \_\_\_\_\_

Medication Prescribed, Dosage, and Reason for Medication: \_\_\_\_\_

**Follow up needed?**  Yes  No

**If yes, reason?** \_\_\_\_\_

**Date of scheduled follow up appointment** \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Doctor/Dentist

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Signature of Doctor/Dentist

\_\_\_\_\_  
Address

**(PLEASE ATTACH A COPY OF THE LAB WORK AND IMMUNIZATIONS IF APPLICABLE)**