Human Services Department
Children and Family Services Division
www.adcogov.org

11860 Pecos Street
Westminster, CO 80234

CHILD'S MEDICAL VISIT FORM

Date of Visit: ________ Child's Name/DOB: __________________ Household #: __________

<u>Type of Visit:</u>

(__Initial Physical) (__Well Baby at age ______) (__ Annual Physical)(__ Other _______)

Name of Physician: ____

Address of Physician: ____

Diagnosis and Treatment given:

Regular Medications Taken by Child/New Prescriptions:

___

☐ Vision Checked

- Comments/Concerns:
- Date of next recommended vision check: ________________

☐ Hearing Checked

- Comments/Concerns:
- Date of next recommended hearing check: ________________

Physician Signature: ____________________________________ Date: ______________

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CHILD'S DENTAL VISIT FORM

Date of Visit:__________ Child's Name/DOB:__________________ Household #:___________

Type of visit: (___Initial) (___6-month) (___Other:____________________)

Name of Dentist:____

Address of Dentist:____

Diagnosis and Treatment Provided/Follow up Dental Work:

Dentist Signature:____ Date:______________