# Well Baby check for Foster Child

**Patient’s name:**

**Today’s date:**

**Name of treating professional (printed):**

**Signature of treating professional:**

**Address and phone number of health office:**

**Rule reference:** 7.710.43

*Colorado Department of Human Services’ Division of Child Care mandates that each foster parent keep written documentation of all medical, dental and optical care appointments of foster children.*

**Name of individual being assessed:**

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| --- |
|  |

**Type of appointment:**

**Reason child is being seen today:**

**Need for follow up:**

**Next visit scheduled:**