# Pathways Family Services

www.pathwaysfamilyservices.com

Month/Year of Reporting Period: _____

## Child/Youth Health & Wellness Form

Foster Home: _____ Child/Youth: _____

*Medical Appointments:*

A **medical** examination is required **within ten (10) days** of the child/youth being placed in the home. During this examination, any injuries, symptoms, ailments and/or history of medication will be shared with the doctor and a treatment plan, if required, will be implemented. Thereafter, the child will be seen at least every twelve (12) months or sooner for an annual checkup or to address any symptoms, ailments, etc.

Child/youth, over the age of three (3) years, who have not had a **dental or optical** examination within one (1) year prior to admission into care shall be examined by appropriate practitioners **within two (2) months** of placement, and annually thereafter. Child/youth under the age of three (3) years at time of placement shall be examined by appropriate practitioners **within two (2) months** of their third birthday, and annually thereafter.

Full Date(s) of Appointment(s) (month/day/year): _____

Check Type of Appointment:

☐ Medical ☐ Dental ☐ Optical ☐ Psychiatric ☐ Psychological ☐ Immunization

☐ Other (specify): _____

Reason for Appointment:

☐ Initial ☐ Annual ☐ On-Going and/or Illness ☐ Emergency

Professional: _____

Medication Prescribed: ☐ Yes ☐ No (if yes – complete reverse) ☐ Medication Review

Comments/Follow up:

Full Date(s) of Appointment(s) (month/day/year): _____

Check Type of Appointment:

☐ Medical ☐ Dental ☐ Optical ☐ Psychiatric ☐ Psychological ☐ Immunization

☐ Other (specify): _____

Reason for Appointment:

☐ Initial ☐ Annual ☐ On-Going and/or Illness ☐ Emergency

Professional: _____

Medication Prescribed: ☐ Yes ☐ No (if yes – complete reverse) ☐ Medication Review

Comments/Follow up:

***If no appointments occurred this month, please indicate by checking:*** ☐

General Comments:

General Comments Continued:

*Multiple Medication:*
Please document name of medication and the time of administration. Caregivers are required to document all medications taken by a child/ youth. This includes such over-the-counter medications as pain killers and cough medicine. Enter the time, date, and type of medication taken below and initial. If the child administers their own medication (with Case Worker's approval), the child needs to initial.

**TYPE OF MEDICATION:** **DOCTOR'S NAME:**

| Dosage | Times | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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**TYPE OF MEDICATION:** **DOCTOR'S NAME:**

| Dosage | Times | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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***If no medications administered this month, please indicate by checking:*** ☐

*Allowance:*
Foster parents must complete this section providing the full date(s), and amount(s) given. Children are expected to sign for themselves upon receipt of allowance. Refer to Pathways Policy FC-17, Point 6. Daily Stipend rate includes the following spending allowance per week:

☐ 6 - 8 = $2.75 ☐ 9 - 11 = $6.95 ☐ 12 - 15 = $11.00 ☐ 16 - 18 = $15.15

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|---|---|---|---|---|---|
| Date(s) | | | | | |
| Amount(s) | | | | | |
| C/Y Initial(s) | | | | | |

***If child is 5 or younger, no allowance is issued, please indicate by checking:*** ☐

Signature

Date

PRINT RESET