KEEPING KIDS SAFE, INC.

417 N. Main St.
Findlay, Ohio 45840

ROUTINE / ILLNESS MEDICAL FORM

Child's Name: _____ D.O.B:_____

Dr. _____ Date: _____

Check One:
□ Illness □ Accident/ Injury □ Follow-Up □ Routine Appointment □ Medication Evaluation □ OT
□ PT □ Speech □ Vaccinations

Reason for Visit: _____
_____
_____

Physician's Diagnosis & Recommendations:

_____
_____

New / Discontinued / Changed Medication:

Medication: _____Time: _____Dosage: _____
Medication: _____Time: _____Dosage: _____
Medication: _____Time: _____Dosage: _____
Diagnoses: □ ADHD □Autism □ Sleep Disturbance □ ODD □ Conduct Disorder
□ Bipolar Disorder □ Depression □ RAD □ Tourettes □ PTSD □ PDD
□ DD □ Trauma □ Other_____

Physician's Instructions, Treatments, Return Appointments Etc.: _____
_____
_____
_____

Physician's Signature: _____ **Date:** _____

Physician's Name Printed _____ **Address:** _____

AGENCY USE ONLY

Adult who attended appt: _____Signed: _____
By signing I acknowledge I was present, understand the diagnosis, medications and/or recommendations
CW who received med form: _____ Signed: _____
By signing I acknowledge I received the information and documented any necessary changes.