**MONTHLY CHILD PROGRESS NOTE – Month/Year:**       **/**

**Child**       **Foster Home**

**Under each heading, please give a brief summary of child’s progress/behaviors and/or services.**

**Medical/Dental/Developmental**

**Appointments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Healthcare Professional** | **Reason for visit/diagnosis** | **Follow up/Recommendations** | **Medication Prescribed**  Yes  No  **(If so, list below)** |
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**List of Current Medications**

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| --- | --- | --- |
| **List of Medications (*to include OTC)*** | **Reason for the Medication** | **Prescribed or OTC** |
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**Child’s Behavioral/Social/Emotional/Daily Routine growth/progress:**

**Therapy:**   Yes  No

**(Including play therapy, BH services and developmental services include frequency and progress):**

**Education:**

**Recreational Activities:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Recreational Activity | Date of activity | Time of activity | Supervision provided by | Behavior during activity |
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**Biological family visits:**

Did child have any contact with biological parents during and/or identified caring family member this review period?  Yes  No

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| --- | --- | --- | --- |
| **Date:** | **Who was present:** | **Date:** | **Who was present:** |
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**Sibling Contact (*other than DFPS/OCOK scheduled family visits*):**

***Requirements: One visit per month with all siblings in separate foster homes within 100 miles. Two phone visits, if more than 100 miles.***

Does child have any siblings in foster care or kinship placement?  Yes  No  N/A

Does the sibling live within 100 miles?  Yes  No  N/A

Does the sibling live more than 100 miles away?  Yes  No  N/A

Did the child have contact this month?  Yes  No  N/A

If no, explain why:

If yes, list with who, contact type and dates

(*Contact type=face to face, email, telephone, text or Skype)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date:** | **Contact Type:** | **With who:** | **Date:** | **Contact Type:** | **With who:** |
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