Texas Department of Family and Protective Services

EXAMPLE

Form K-905-2403
Revised February 2020

MEDICAL, DENTAL, VISION, HEARING, OR BEHAVIORAL HEALTH APPOINTMENT

Purpose: Use this form to document medical, dental, vision, hearing and behavioral health (Child and Adolescent Needs and Strengths assessment (CANS)) appointments.
Completion of this form meets requirements in:

- Residential Child Care Licensing Minimum Standards
- Residential Child Care Contracts
- Child Protective Services policy

Completion of this form is not required for allied health services such as physical therapy, occupational therapy, speech therapy, or dietary services.

Directions: The person taking the child or youth completes Section I of this form on each visit with a health care provider. When possible, Section II is completed by the health care provider.

If the health care provider is unable to complete Section II, the person taking the child or youth to the appointment completes Section II, signs his or her name, and checks the box labeled: *health care provider unable to complete*. The health care provider may attach medical records or other information to this form in lieu of completing Section II.

The caregiver provides a copy of the completed form to the CPS caseworker to file in the case record.

SECTION I. CHILD'S INFORMATION			
Child's Name: Jimmy Joe Smith	Date of Birth: 07/01/2019	Person Identification (PID) Number:	Appointment Date: 08/04/2021

CAREGIVER INFORMATION			
Caregiver can be a foster parent, relative, non-relative, or representative of a residential operation who is taking the child to the health care provider.			
Caregiver's Name: John and Jane Doe	Phone: (111) 111-1111	Agency: CK Family Services	
Address: 1 CK Street	City: Arlington	State: Texas	Zip: 76018

CASEWORKER INFORMATION		
Caseworker's Name: Sally Mae Jones (DFPS or OCOK Worker)	Phone Number: (222) 222-2222	Fax:

REASON FOR VISIT

☐ **3-Day Medical Exam.** (Required within three business days of removal with some exceptions, such as DFPS removal while child is in a hospital setting). Immunizations are not allowed at this exam unless an emergency situation requires tetanus vaccination, or if the provider gets direct consent from the biological parent(s).

☐ **Child or Youth with Primary Medical Needs.** (Required within seven days before or three days after placement date).

☐ **Initial Child and Adolescent Needs and Strengths (CANS) Assessment.** (Required within 30 days of entering DFPS conservatorship).

☐ **Child and Adolescent Needs and Strengths Update (CANS) Assessment.** (Required annually; may be required more frequently in some areas).

☒ **Routine Texas Health Steps Medical Checkup.** (Required at the following ages: within five days after discharge from the newborn hospitalization, at 2 weeks of age, at 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 36 months, and then annually).

☐ **Other Medical Checkup.** Reason:

List the type of visit and reason for the visit

Regular Well-Child Exams

☐ **Initial Texas Health Steps Dental Checkup.** (Required within 60 days of entering DFPS conservatorship if the child is 6 months of age or older, or within 30 days of turning age 6 months).

☐ **Initial Texas Health Steps Medical Checkup.** (Required within 30 days of entering DFPS conservatorship).

☐ **Routine Texas Health Steps Dental Checkup.** (Required every six months or as recommended by a dentist).

☐ **Other Dental Checkup.** Reason:

List the type of visit and reason for the visit

First Dental Check-up

First Well-Child Exam (within 30 days)

☒ **Vision Check.** ☒ **Hearing Check.**

☐ **ER Visit.** – Reason:

List the type of visit and the reason for the visit

Or Urgent Care Visit

☐ **Specialty Visit.** Reason:

List the type of visit and reason for the visit

☐ **Illness, injury or accident or other follow-up visit.** (Describe the injury, accident or illness, including the date and time of the incident.)

If the medical visit is due to any illness, injury, or accident, provide details regarding symptoms, what happened, and when it happened. Check this box for any follow-ups for follow-ups for illness, injuries, or accidents as well.

MEDICATIONS

☐ No ☐ Yes (List) Caregiver Comments: **If yes list all medication below**

Medication	Dosage	Prescribed for	Instructions
Cetirizine (Name of Medication)	5 mL of 1 mg/1 mL (The amount given to the child, and the strength)	Allergies (Why is the medication being taken?)	Give 5 mL once daily PRN (Instructions as written on label)

This section is meant for medications the child is already on. New, changed, or discontinued medications will be documented on page 7.

Caregiver Comments:

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SIGNATURE OF PERSON COMPLETING SECTION	
DFPS Staff or Caregiver Signature: **X** Foster parent's signature here	Date Signed: 08/04/2021

SECTION II. HEALTH CARE APPOINTMENT (TO BE COMPLETED BY HEALTH CARE PROVIDER)		
Child or Youth's Name: Jimmy Joe Smith	Date of Birth: 07/01/2019	Appointment Date: 08/04/2021

VISIT RESULTS

☐ Child or youth refused appointment

VITALS:

Years:	Months:	Weeks:	Temperature:	Pulse:	Respirations:	Blood Pressure:
2	1		98.6			

Height:	Weight:	Head Circumference:	BMI:
24%: Feet/inches	38%: Pounds/ounces	55%: centimeters	%:

VISION SCREEN: **R:** 20/ **L:** 20/

☐ No glasses ☐ Glasses ☐ Did not bring glasses

☒ Subjectively normal ☐ Not done ☐ Child or youth unable to comply with screening ☐ Refused

☐ Complete eye examination recommended

HEARING SCREEN:

	500Hz	1000Hz	2000Hz	4000Hz
R				
L				

☒ Subjectively normal ☐ Not done ☐ Child or youth unable to comply with screening ☐ Refused

☐ Complete audiology examination recommended

PROCEDURES OR TESTS: ☒ None ☐ TB screen ☐ Lead screen ☐ Developmental screen

☐ Autism screen ☐ Hemoglobin ☐ PPD ☐ Blood lead test ☐ Other (list):

DIAGNOSES: Mild Eczema

The hearing and vision screening sections are for the doctor's observations if a screening is not completed check not done. If the doctor has no concerns, have them mark subjectively normal. This CANNOT be checked "Not done" for regular Well-Child Exams. If the vitals are not completed on this form we need the AVS and that section highlighted. Put "See AVS" next to Vitals:

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Explain what type of appointment by checking the correct box.

☐ Well Child ☐ Routine Dental Visit ☐ Other (list):

Name	Dosage	Prescribed for	Instructions	Discontinued	New	Changed
Hydrocortisone Cream	USP 2.5%, pea-sized amount	Mild Eczema	Apply a pea-sized amount to affected areas PRN.	☐	☒	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

Any new medications that were prescribed at this appointment go here. Also, if any dosages change or current medications are discontinued, please list them here.

☐ No Medication Changes

VACCINES: Children and youth are prohibited from receiving vaccinations at the 3-Day Medical Exam unless an emergency situation requires tetanus vaccination, or if the provider gets direct consent from the biological parent(s).

☒ None Administered

Don't forget to fill out these boxes, if applicable.

☐ DTap ☐ Tdap ☐ HIB ☐ PCV ☐ Td ☐ MMR ☐ Varicella ☐ Hep A ☐ Hep B ☐ IPV ☐ HPV
☐ MenA ☐ MenB ☐ Rotavirus ☐ Influenza ☐ PCV13 ☐ PPSV23
☐ Other (list):

REFFERED TO:

List any referrals made to any specialists that might be needed, or any of the below services. Check "None Necessary" if no referrals were made. Check the boxes below if a referral was made.

☒ None Necessary
☐ ECI (Early Childhood Intervention) ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy
☐ Specialist (Type): ☐ Other (Type):

FOLLOW-UP:

Make sure to note if any follow-up appointments were requested by the doctor.

☒ None Necessary
☐ Return Visit: When and Why

Provider Comments:

This section is meant for any comments from the medical provider.

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PROVIDER INFORMATION		
Provider Signature: **X** PROVIDER'S SIGNATURE, IF ABLE	Clinic Name: Cook's Fostering Health Clinic	Phone: (682) 303-6800
Printed Name: Dr. Jane Jones	Address: 801 7th Avenue	Fax:
Date Signed: 08/04/2021	City, State, Zip Fort Worth, TX 76104	
If Section II is not completed by a medical or dental provider, the caregiver sign below.		
Caregiver Signature: **X** YOUR SIGNATURE HERE	Date Signed: 08/04/2021	**Only one signature is needed if the Provider signs the Caregiver signature is not needed.**
☐ *The health care provider was unable to complete this form.*		

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our Privacy and Security Policy.

Check this box and sign your name if the doctor or medical professional is unable to sign the form. You are able to fill out the form if the doctor does not.