Alaska Department of Health and Social Services
Office of Children's Services

Medical, Dental, and Medication Record

Child's Name _____ **Emergency Contact Name** _____

Birth Date _____ **Address** _____

Medical Plan _____ **Phone** _____

Medicaid Number _____ **Alternate Phone**

Medical / Dental Visits

Date	Nature of Visit	Attending Physician	Prescribed Medication	Diagnosis/Recommendations/Notes

For each visit to a physician, health center or dentist, enter date (month/day/year), complete name of the provider, prescribed medications, what was done, and recommendations. All evasive treatment must be prior approved by the guardian.

This form is to be given to the child's placement worker when requested and/or when the child leaves the foster home.

Medication Log

Name:

Known allergies:

Date:

Name of Medication	Date Started	Dosage, Dosage Times	Refill Number	Pharmacy Phone Number	Physician Name and Phone Number	Comments

All medication and/or dosage changes must be approved by the guardian.