PA*Child*

**M E D I C A L T R E AT M E N T F O R M**

Child: ................................................................................. DOB: ................................................... Resource Parent: ................................................................ Date of Visit: .......................................

Physician’s Name: ............................................................. Telephone #: ........................................ Address: ............................................................................................................................................

Nature of Visit: ..................................................................................................................................

............................................................................................................................................................ Diagnosis: .........................................................................................................................................

............................................................................................................................................................ Treatment/Recommendations: ...........................................................................................................

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Follow Up Treatment Needed: □ Yes □ No

Follow Up Recommendations: .........................................................................................................

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Print Name and Title of Examiner: ................................................................................................... Signature of Examiner: .....................................................................................................................

as of 1/1/2011