DPP-106D
(R. 8/11)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services

# MEDICAL APPOINTMENT

TODAY'S DATE: _____
CHILD'S NAME: _____ DOB:_____
DCBS CASE NUMBER: _____
REASON FOR VISIT: _____

| | |
|---|---|
| **Exam:** (Please Describe any abnormal findings): Wt: Height: Temp: B/P: Pulse | |
| **Findings/Diagnosis** | |
| **Recommendations**<br><br>**Follow-up:** | |
| **Signatures** | |
| **Health Care Provider** | **Name:** |
| | **Signature:** |
| | **Attending Appointment with Child (as appropriate)** |
| **Birth Parent** | **Name:** |
| | **Signature** |
| **Foster Parent** | **Name:** |
| | **Signature:** |
| **DCBS** | **Name:** |
| | **Signature:** |

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