MEDICAL FOSTER CARE PROGRAM
DISCHARGE FORM

Name:_____ SS#: _____
AKA: _____ Nickname: _____ DOB: _____

Date of Discharge from MFC: _____ Pediatrician (after D/C fromMPH): _____

Discharged to: _____/_____
Name Relationship

Street Address/City/State/Zip Phone

CPS Worker: _____PI-PS-FC-VFS Phone #: _____
Other Worker: _____ Program: _____ Phone #: _____
Medicaid #: _____ Other Insurance: _____
WIC: _____ Office Address: _____ Phone #: _____
WIC under what name: _____

DIET:
Formula: _____ Powder/Concentrate/Ready to Feed
Amount per feeding: _____ Bottle/Cup Number of feedings per day: _____
Foods: (kind, amount, number of feedings)
_____
_____
Likes and dislikes:
_____
_____
Problems with feedings:
_____
_____
Appetite: Good _____ Average _____ Poor _____
ELIMINATION PATTERN:
Number of bowel movements per day _____ Potty trained: _____ Days dry at nap? _____ At night? _____

BEHAVIOR:
Bedtime: _____ Naps: _____
Bedtime routine:
_____
_____
Play activities:
_____
_____
Discipline problems:
_____
_____
Fears:
_____
_____

DEVELOPMENT:
Sits alone: _____
Rolls over: _____
Crawls: _____
Walks: _____
Speech: _____

Activity normal for age? _____Yes _____ No
Therapies:
PT: ___ Where: _____ Telephone #: _____ How often: _____
OT: ___ Where: _____ Telephone #: _____ How often:_____
ST: ___ Where: _____ Telephone #: _____ How often: _____
Other: ___ Where: _____ Telephone #: _____ How often: _____

MEDICAL PROBLEMS:
Pediatrician (while in MFC): _____ Last time seen: _____
Address: _____ Tel #: _____
Diagnosis:
_____
_____
Allergies: _____
Height: _____ Weight: _____ HC: _____ Date Taken: _____
Other MD Specialists: _____ Tel #: _____
_____ Tel #: _____
_____ Tel #: _____
CMS Patient: Yes _____ No _____ CMS Nurse: _____

Past Medical History (including hospitalizations & surgeries):
_____
_____
_____
_____

	Medications:	Dose:	Frequency:	Comments:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

(Use additional sheet if necessary)

Treatments:
_____
_____
_____
_____

MEDICAL PROBLEMS continues

Equipment/Vendors: Tel. #:

Scheduled appointments (include date, time, doctor's name or clinic):

Immunizations: (List, include dates and where given)

School Info:
Attends which school: _____ Tel #: _____
Transportation needs: _____
School hours: _____
Teacher's name: _____
Other contact person & tel #: _____
Other **important** info:

SPECIAL INSTRUCTIONS:
(Example: Signs and symptoms of the child when presenting in medical crisis)

MPH Parent's name and telephone number (optional):

MFC Program Contact name and telephone number:

ITEMS SENT WITH CHILD:

I have received the items listed above. I understand the discharge instructions and will give the medications and treatments as ordered.

_____ _____

Signed Date