

CHOICES FOR LIFE FOSTER CARE

OKC

Checotah

Sapulpa

Valdosta

Examination Form (Circle Appropriate Type of Visit)

Medical

Dental

Vision

Psychiatric

CLIENT: _____

DOB: _____

MED #: _____

KK #: _____

Appointment Date and Time: _____

Physician's Name: _____

Address: _____

Telephone: _____

Client is free of communicable disease: ___ Yes ___ No

Describe any medical issues or concerns:

Physician Signature

Date