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 **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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