



ONGOING MEDICAL SERVICES FORM

Youth Name: _____ D.O.B. _____

Date of Exam: _____ Purpose of Exam: _____

Type of Exam: _____ Physician _____ Dentist _____ Optometrist _____ Psychiatrist
_____ Psychologist _____ Other: _____

Findings _____

Treatment Recommended _____

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Health Provider _____ Date _____

Print Name of Health Provider: _____

Name of Medical Facility: _____

If mailing this form, please return to: