MEDICAL / DENTAL
APPOINTMENT FORM

CHILD: ________________________________ **DOB:** ________________

PHYSICIAN / DENTIST: ____

ADDRESS: ____

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DATE & TIME OF APPT: ____

REASON FOR APPT: ____

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CONCLUSIONS: ____

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MEDICATIONS/TXT
RECOMMENDATIONS: ____

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IS CHILD FREE OF COMMUNICABLE DISEASE? ____________________

FOLLOW UP: ____

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PHYSICIAN/DENTIST SIGNATURE **DATE**

PLEASE MAIL FORM TO: MERCER COUNTY CHILDREN AND YOUTH SERVICES
8425 SHARON-MERCER ROAD
MERCER, PA 16137

OR FAX TO: (724)662-0676