**MONTHLY CHILD PROGRESS NOTE – Month/Year:**       **/**

**Child**       **Foster Home**

**Under each heading, please give a brief summary of child’s progress/behaviors and/or services.**

**Medical/Dental/Developmental**

**Appointments**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Healthcare Professional**  | **Reason for visit/diagnosis** | **Follow up/Recommendations** | **Medication Prescribed**[ ]  Yes [ ]  No**(If so, list below)**  |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

**List of Current Medications**

|  |  |  |
| --- | --- | --- |
| **List of Medications (*to include OTC)*** | **Reason for the Medication**  | **Prescribed or OTC** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

**Child’s Behavioral/Social/Emotional/Daily Routine growth/progress:**

**Therapy:**  [ ]  Yes [ ]  No

**(Including play therapy, BH services and developmental services include frequency and progress):**

**Education:**

**Recreational Activities:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Recreational Activity | Date of activity | Time of activity | Supervision provided by | Behavior during activity |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

**Biological family visits:**

Did child have any contact with biological parents during and/or identified caring family member this review period? [ ]  Yes [ ]  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** | **Who was present:** | **Date:** | **Who was present:** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Sibling Contact (*other than DFPS/OCOK scheduled family visits*):**

***Requirements: One visit per month with all siblings in separate foster homes within 100 miles. Two phone visits, if more than 100 miles.***

Does child have any siblings in foster care or kinship placement? [ ]  Yes [ ]  No [ ]  N/A

Does the sibling live within 100 miles? [ ]  Yes [ ]  No [ ]  N/A

Does the sibling live more than 100 miles away? [ ]  Yes [ ]  No [ ]  N/A

Did the child have contact this month? [ ]  Yes [ ]  No [ ]  N/A

If no, explain why:

If yes, list with who, contact type and dates

(*Contact type=face to face, email, telephone, text or Skype)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date:** | **Contact Type:** | **With who:** | **Date:** | **Contact Type:** | **With who:** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |