BERKS COUNTY CHILDREN & YOUTH SERVICES
RESOURCE PARENT MONTHLY REPORT

[BCCYS Use Only] Date Rec'd: _____

MONTH AND YEAR: _____

CHILD'S NAME: _____ AGE: _____

CASEWORKER: _____ COORDINATOR: _____

FOSTER FAMILY NAME: _____

DOCTOR'S NAME: _____

LIST FAMILY MEMBERS WHO ATTENDED EACH DR. APPOINTMENT: _____

_____

DOCTOR APPOINTMENTS: _____

PURPOSE OF APPOINTMENT AND RECOMMENDATIONS: _____

_____

_____

IMMUNIZATIONS GIVEN AND MEDICATIONS PRESCRIBED (name and quantity):

_____

_____

COURT DATE: _____ CASEWORKER HOME VISITS: _____

CHILD VISITS (date and with whom): _____

_____

REACTIONS TO VISITS: _____

_____

_____

_____

_____

_____

_____

THERAPY/COUNSELING: _____

DATES: _____

PROBLEMS/REACTIONS: _____

SCHOOL MEETINGS/APPOINTMENTS: _____

SCHOOL PROBLEMS/BEHAVIORS: _____

OTHER COMMENTS (MILESTONES, PROBLEMS, REACTIONS, ISSUES, ETC.):