CALIFORNIA FOSTER FAMILIES, INC. MONTHLY PROGRESS REPORT

Child:_____ **CFH:**_____ **Month/Year**_____

Foster Parent Signature:_____

Print Name:_____

CONTACTS WITH MENTAL HEALTH PROFESSIONAL (PSYCHIATRIST, PSYCHOLOGIST, THERAPIST)	***ILSP DATES OF ATTENDANCE***
Name/Phone Number:	
Dates of contact:	
Outcome/Follow-up Information:	

Contact With Biological Family				
Date	**With Whom**	**Length**	**Location**	**Child's Behavior/Attitude Around Visits**

Medical /Dental Appointments		
Name/Phone Number	**Date of Contact**	**Outcome/Follow-up Information**

Foster Parent Notes:

FOR OFFICE USE ONLY - Following items must be in the child office binder

Centrally Stored Medications	☐ Yes	☐ No
Monthly Medication Log	☐ Yes	☐ No
Audit Child Home Binder this Month	☐ Yes	☐ No
Audit Child Office Binder this Month	☐ Yes	☐ No

ASW Initials:_____ Social Worker Supervisor Initials:_____

Print ASW Name:_____