

Date	Health/Service Provider or Activity	Reason for Visit	Type of Appointment
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services
			<input type="checkbox"/> CHDP Medical/Dental <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Supportive Services

*****If additional space is necessary please attach additional sheets***

BEHAVIOR CHALLENGES No significant behavior challenges in this reporting period

Date(s)	Description of Behavior **Attach Incident Report**

EXTRACURRICULAR/SPORTING ACTIVITIES: Check all that apply No extracurricular or sports

<input type="checkbox"/>	After school program	<input type="checkbox"/>	Soccer	<input type="checkbox"/>	Baseball/softball	<input type="checkbox"/>	Football
<input type="checkbox"/>	Track/field	<input type="checkbox"/>	Dance	<input type="checkbox"/>	Gymnastics	<input type="checkbox"/>	Basketball
<input type="checkbox"/>	Music/choir	<input type="checkbox"/>	Art	<input type="checkbox"/>	Tutoring	<input type="checkbox"/>	School club
<input type="checkbox"/>	Play group	<input type="checkbox"/>	Religious activities	<input type="checkbox"/>	ILSP activities	<input type="checkbox"/>	Scouts or YMCA
<input type="checkbox"/>	Other:			<input type="checkbox"/>	Other:		

FOSTER PARENT TRAININGS COMPLETED THIS QUARTER No Trainings

Date(s)	Description of Training and/or Topics **Attach Certificates**

The following is a list of requirements based upon SCR Levels. Please mark all that apply.

- I have provided transportation to appointments during review period.
- I am current with all licensing or home approval requirements and training hours.
- I participate in monthly social worker contacts and teacher conferences.

Foster Parent Signature

Date

Please make sure that you have accurately completed this report. Your answers are used to validate continued eligibility for the SCR program. When completed, return to the following address:

**Tehama County Department of Social Services
PO BOX 1515, Red Bluff, CA 96080
ATTN: PST**

For Department Use Only

- MATT Referral/Child's needs appear to exceed Level 3
- Verified that Caregiver is current with all licensing or home approval requirements and training hours.

SCR Approval/Assessment Date: _____ **Approved Level** _____

Suggested Training Topics and PST comments:
