

**WHIMSPIRE  
Youth Health Care Visit Form**

**Youth Name:** \_\_\_\_\_ **Date of Visit:** \_\_\_\_\_

**Reason for Visit:**

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**Treatment/Testing by Doctor/Dentist:**

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**Authorized Non-prescription Medications:**

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**Other Treatment Recommended:**

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**Next Visit:** \_\_\_\_\_

**DOCTOR/DENTIST'S PRINTED NAME:** \_\_\_\_\_

**DOCTOR/DENTIST'S SIGNATURE:** \_\_\_\_\_

**DOCTOR/DENTIST'S ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_