



Pathways Family Services

www.pathwaysfamilyservices.com

Foster Parent Month End Report

CHILD'S NAME: _____

MONTH/YEAR OF REPORT: _____

CASE WORKER: _____

CHILDREN SERVICES OFFICE: _____

FOSTER HOME: _____

DATE OF PLACEMENT IN HOME: _____

**POINTS 1 – 4 ARE FOR *SHORT TERM PLACEMENTS ONLY*
(CHILDREN PLACED LESS THAN ONE YEAR) OR IF SIGNIFICANT CHANGES HAVE OCCURRED:**

1. How is the child responding to the routine and structure in the home?

2. Describe any concerns with the child's behaviour(s) with particular emphasis on their adjustment to the home. What strategies were used to aid the child in adjusting to the home?

3. Describe child's interactions with caregivers and other adults:

4. Describe child's interactions with their peers (e.g. cooperative, withdrawn, aggressive, sociable, assertive, leader, follower, etc.):

FILL OUT REMAINDER OF REPORT FOR *BOTH SHORT TERM & LONG TERM PLACEMENTS*

GENERAL:

5. Comment on the child's progress/behaviour/activities/attendance in school (including Head Start & Early Intervention):

6. Comment on any special celebrations (e.g. birthdays, Family Day activities, etc.):

7. If you attended church or another organized religious ceremony, did the child attend with you? Yes No

8. Describe the child's recreational/free time activities (e.g. organized sports, computer, reading, crafts, TV, etc.):

9. Is Allowance Form attached? Yes No

Was allowance money saved or spent? If spent – on what?

10. Was there any contact with the Children Services Case Worker this month? Yes No

If yes, specify type. *Please ✓ all that apply:*

Phone Call	<input type="checkbox"/>	Date(s):	_____
E-mail	<input type="checkbox"/>	Date(s):	_____
Face to Face	<input type="checkbox"/>	Date(s):	_____

DEVELOPMENTAL PROGRESS/LIFE SKILLS:

11. Describe the child's physical/speech development and note any apparent delays:

12. Describe the child's skill development, milestones reached, and any progress towards independence:

13. *If applicable*, describe the child's involvement in their employment:

SIGNIFICANT EVENTS OR CHANGES:

14. Comment on any achievements for the child:

15. Were there any Critical Incident Reports Submitted this month? Yes No

16. Describe any problematic activities/behaviours the child has been involved in (at home or in the community):

17. Were consequences required as a result of child's behaviour(s)? If so – how frequently and what is the child's response?

RESPIRE/ADDITIONAL SUPPORTS:

18. Was child placed in respite this reporting period? Yes No

If so, provide dates and names of respite providers. Describe the child's reaction if any to respite:

Date(s):	Respite Provider(s):	Reaction(s):

19. Were there any additional supports provided by Children Services (e.g. tutoring, youth workers, etc.). Please provide details and note frequency.

CULTURAL/ABORIGINAL INVOLVEMENT:

20. Was the child involved in cultural/Aboriginal activities this month (e.g. Pow Wow, books, community groups, etc.)?

Yes No

Describe the activities or reasons for lack of:

HEALTH/MEDICAL:

21. Describe the child's emotional state this month (e.g. happy, moody, withdrawn, etc.):

22. Describe the child's physical health during this month:

23. Please comment on child's hygiene, sleep patterns (e.g. interrupted sleep, hard to put to sleep, etc.), and diet/appetite (e.g. no appetite, hoarding, insatiable, etc.):

24. Was any medication administered? Yes No Is Medication Form attached? Yes No

Comment on reactions to medication, if any:

25. Comment on any changes to medications (e.g. type, dosage, frequency):

26. Were there any appointments (medical and other) this reporting period? Yes No

List all appointments in boxes provided below. For "Type" please choose from the following examples:

- Medical
- Dental
- Optical
- Orthodontic
- Immunization
- Psychological
- Psychiatric
- Occupational Therapy (OT)
- Physio Therapy (PT)
- Speech Therapy (ST)
- Hearing
- Assessment
- Other

NOTE: Please list complete date for all appointments (e.g. Oct 1/09)

APPOINTMENTS:

Type:	Date:	Professional:
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Comments:

Type:	Date:	Professional:
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Comments:

Type:	Date:	Professional:
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Comments:

FAMILY CONTACT:

27. Has the child had any family or sibling contact during this reporting period: Yes No

If so, what type of contact? Please \checkmark all that apply:

Phone Call(s) <input type="checkbox"/>	Cards/Letters <input type="checkbox"/>
E-mail(s) <input type="checkbox"/>	Face to Face <input type="checkbox"/>

Specify type(s) of visits. Please \checkmark all that apply:

Supervised Un-Supervised Over night Sibling Other Unknown

Please list dates and times of visits this month (**NOTE – Type refers to supervised, etc. – see above**):

Date:	Time:	Type:	Date:	Time:	Type:

28. Please note child's reactions if visits *did occur*:

29. Please note child's reactions if visits *did not occur (were cancelled)*:

REPORT COMPLETED BY:

Foster Parent's Signature

Date Report Completed