



# 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?

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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?

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

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 Describe child's interactions with their peers (e.g. cooperative, withdrawn, aggressive, sociable, assertive, leader, follower, etc.):

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**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):

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

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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.):

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9. Allowance - NOTE: If a child is 6 years of age or older, an allowance form is required.

Please fill out a separate "Child/ Youth Allowance and Medication Record" and attach to this report.

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:

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

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

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**SIGNIFICANT EVENTS OR CHANGES:**

14. Comment on any achievements for the child:

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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):

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

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

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**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:

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**HEALTH/MEDICAL:**

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 Describe the child's emotional state this month (e.g. happy, moody, withdrawn, etc.):

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

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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.):

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

Comment on reactions to medication, if any:

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

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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) and indicate if the appointment was: On-going, Emergent, Annual or Initial**

**APPOINTMENTS:**

|                  |                                   |                                   |
|------------------|-----------------------------------|-----------------------------------|
| Type:            | Date:                             | Professional:                     |
| Appointment was: | On-going <input type="checkbox"/> | Emergent <input type="checkbox"/> |
| Comments:        | Annual <input type="checkbox"/>   | Initial <input type="checkbox"/>  |
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|------------------|-----------------------------------|-----------------------------------|
| Type:            | Date:                             | Professional:                     |
| Appointment was: | On-going <input type="checkbox"/> | Emergent <input type="checkbox"/> |
| Comments:        | Annual <input type="checkbox"/>   | Initial <input type="checkbox"/>  |
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|------------------|-----------------------------------|-----------------------------------|
| Type:            | Date:                             | Professional:                     |
| Appointment was: | On-going <input type="checkbox"/> | Emergent <input type="checkbox"/> |
| Comments:        | Annual <input type="checkbox"/>   | Initial <input type="checkbox"/>  |
|                  |                                   |                                   |
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**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)  Cards/Letters   
E-mail(s)  Face to Face

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

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

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**REPORT COMPLETED BY:**

\_\_\_\_\_  
Foster Parent's Signature

\_\_\_\_\_  
Date Report Completed