**PEDIATRIC DOCTOR’S NOTE**

**[Pediatric Clinic Name]**

**[123 Health St.,]**

**[Wellness City, ST 12345]**

**[City, State, Zip]**

**Patient Information:**

|  |  |  |
| --- | --- | --- |
| Child's Name:  |  |  |
|  |  |  |
| Date of Birth:  |  | \_\_/\_\_/\_\_\_\_ |  | Gender:  |[ ]  Male |[ ]  Female |
|  |  |  |  |  |  |  |  |  |
| Date of Visit:  |  | \_\_/\_\_/\_\_\_\_ |  | Patient ID:  |  |

**Parent/Guardian Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name:  |  |  | Relation to Child:  |  |

**Diagnosis/Assessment:**

|  |
| --- |
|  |

**Treatment Plan:**

|  |  |  |
| --- | --- | --- |
|  |  |  |

**Dates of Absence**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| From: | \_\_/\_\_/\_\_\_\_ |  | To: | \_\_/\_\_/\_\_\_\_ |

**Doctor Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name:  |  |  | Medical license:  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Date |