

**TUSCARAWAS COUNTY JOB & FAMILY SERVICES  
CAREGIVER MONTHLY REPORT**

Child: \_\_\_\_\_ Month/Year: \_\_\_\_\_

Caregiver: \_\_\_\_\_ Case Manager: \_\_\_\_\_

**CHILD'S ADJUSTMENT (interaction with caregivers/interaction with other family members, friends, peers):**  
\_\_\_\_\_

**CURRENT MEDICATIONS (include dosage, frequency, and time given, e.g., Abillify, 100 mg, daily, a.m.):**  
\_\_\_\_\_

**BEHAVIOR:**

Positive Behaviors: \_\_\_\_\_

Rewards Used: \_\_\_\_\_

Negative Behaviors: \_\_\_\_\_

Discipline (note if discipline used is effective or ineffective in changing negative behaviors): \_\_\_\_\_

**SCHOOL PROGRESS (attach grade report each grading period, note progress, school conferences):**  
\_\_\_\_\_

**VISITATIONS (include dates, child's behavior—if visits occur in your home, include times and observations):**  
\_\_\_\_\_

**COUNSELING (include dates, name of counselor, foster parent consultations):**  
\_\_\_\_\_

**INTERESTS/HOBBIES (how does child spend leisure time?):**  
\_\_\_\_\_

**OBSERVATIONS ON CHILD'S FUNCTIONING?**

Developmental Status: \_\_\_\_\_

Emotional Status: \_\_\_\_\_

Mental Ability: \_\_\_\_\_

Child Health Record Attached

**ARE YOU COMFORTABLE WITH THIS PLACEMENT?**     Yes     No  
Describe: \_\_\_\_\_

**SPECIAL PROBLEMS, COMMENTS, SUGGESTIONS?**  
\_\_\_\_\_

**EXCEPTIONS TO TRANSPORTATION POLICY:**

Name of Driver: _____	Name of Driver: _____
Date of Event: _____	Date of Event: _____
Event: _____	Event: _____

**OVER-NIGHT STAYS with friends or extended Foster Family members:**

Name & Address of Household: _____
Relationship to Child/Foster Family: _____
Date of Over-night Stay: _____
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Name & Address of Household: _____
Relationship to Child/Foster Family: _____
Date of Over-night Stay: _____

**REVIEWED BY:**

Supervisor: _____	Foster Care Worker: _____	Case Manager: _____
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