REPORT OF PHYSICAL EXAMINATION FOR CHILD IN FOSTER CARE

CASE WORKER NAME

CASE NAME

CASE WORKER CODE PHONE NO.

PATIENT'S NAME (LAST) (FIRST) (MI)

MEDICAL I.D.NUMBER

RESPONSIBLE PERSON'S NAME (LAST) (FIRST)

RESPONSIBLE PERSON'S ADDRESS (STREET) (CITY) (ZIP)

PATIENT'S BIRTHDAY			SEX	DATE OF EXAM		
MO	DAY	YR	F M	MO	DAY	YR

MEASUREMENTS

Height:___________

Blood Pressure

Systolic or Diastolic ____/_______

Weight___________ Het/Hgt___________________

☐ Ambulatory ☐ Non-Ambulatory

Head Circumference:_________ Birth Wt.:____________

(Up to 2 yrs.)

IMMUNIZATIONS

TYPE	Up to Date	Given	Total Since Birth	Status Unknown
DPT/Td				
H. Flu				
Polio				
MMR				
Hepatitis B				
Varicella				
Pneumovax				
Hepatitis A				
Influenza				

***Risk Factor required*

Comments/Problems: If a problem is diagnosed, please enter you diagnosis in this area.

ASSESSMENTS	**Normal**	**Abnormal**	**Not Given**
Health & Development History			
Physical Examination			
Development Assessment			
Dental Assessment			
Nutrition Evaluation			
Vision Screening			
Audiometric Screening			
Hematocrit or Hemoglobin			
Urinalysis			
Mantoux (PPD) TB Test			
Blood Lead Test			
Chlamydia Culture*			
GC Culture*			
Pap Smear*			
Ova and Parasites*			

**only when indicated by history and physical exam*

(NAME/ADDRESS/PHONE NO. OF EXAMING PHYSICAN)
(PLEASE PRINT OR TYPE)

(TO BE COMPLETE BY SOCIAL WORKER)

CHDP brochure/ explanation give _______________
Date

CHDP Services Requested: (circle one)

01-Information
03- Medical and Dental
04- Medical and Dental with scheduling and/or transportation
05-Medical only
06- Medical only with scheduling and/or transportation
07—Dental only
08- Dental only with scheduling and/or transportation
09-No referral need; child under care

SIGNATURE OF PHYSICIAN **DATE**

Return completed exam in envelope provided