

KEEPING KIDS SAFE, INC.  
Foster Care Agency

Child's Initial & Yearly Physical Examination

Child's Name \_\_\_\_\_ Date of Exam \_\_\_\_\_  
Child's Date of Birth \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

CHILD'S MEDICAL HISTORY

Measles ( 7 day) _____	Broken Bone(s) _____
Chicken Pox _____	Operation(s) _____
Rheumatic Fever _____	Speech Problems _____
Scarlet Fever _____	Emotional Problem _____
Asthma _____	Physical Handicap _____
Mumps _____	Heart Condition _____
Seizures _____	
Allergies _____	

MEDICATIONS

Is this child on any medication? \_\_\_\_\_ If So, What? \_\_\_\_\_

What medication was prescribed today? \_\_\_\_\_

**REASON SEEN TODAY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EXAMINATION**

Physical Exam	WNL	ABNL	Area of Concern
Head			
Eyes			
ENT			
Dental			
Respiratory			
Heart			
Skin			
Nutrition			
Abdomen			
Neurological			
Speech			
Posture			

Comments/Recommendations \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician \_\_\_\_\_  
Date \_\_\_\_\_