KEEPING KIDS SAFE, INC.
Foster Care Agency

Childs Initial & Yearly Physical Examination

Childs Name_____ Date of Exam _____
Childs Date of Birth _____
Height: _____ Weight: _____ Blood Pressure: _____

CHILDS 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_____
Did the youth receive vaccinations today? _____ If so, what? _____

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 _____
_____

This youth ☐ IS ☐ IS NOT physically capable of participating in agency, community, and athletic events / activities.

If not, why?_____

Physician's Address: _____ _____
Signature of Physician

_____

_____ _____
Date

Physician's Phone Number: _____

Adult who attended appt.:_____
CW who received med form: _____ Date: _____