PHYSICAL EXAMINATION FORM (*for Foster Children)*

Last Name:	First Name:		Date of Birth:
Allergies: _____ NKA ☐		Complaints:	
Weight:		Height:	
Temperature:		Blood Pressure:	
PHYSICAL EXAM	Well check for age: _____		
Are the following normal?	**Normal**	**Describe Abnormal Findings**	**Labs Ordered**
Skin/Hair/Nails			TB test ☐ Blood lead test ☐ Additional: Hgb/Hct: ☐ Urinalysis ☐ Other:_____ _____ _____ _____ _____ _____ _____
Ears/Hearing			
Eyes/Vision			
Mouth/Throat/Teeth			
Nose/Head/Neck			
Lungs			
Heart			
Abdomen			
Genitourinary			
Extremities			
Back/Hips			
Neurological			
Immunizations given:			
Anticipatory Guidance given:			

IMPRESSIONS/TREATMENT PLAN/ RECOMMENDATIONS:

_____

_____

REFERRALS:

_____

Physician's signature: _____ Date: _____

Address: _____

Phone: _____