Copy given to_____, caregiver, on ____/_____/_____by_____

CHILD PHYSICAL EXAMINATION

(Please print all information)
Child's Name _____ Date of Birth _____ Sex ____ Race/Eth.____
County DSS _____ Name of Social Worker _____
Person Accompanying Child _____
Name of Examining Physician _____
Address_____ Telephone ( ) _____

PHYSICAL EXAMINATION FINDINGS

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____/_____
Height ___ (Percentile) ____ Weight _____ (Percentile) ____ Head Circum. ___(Percentile) ____

Screening

Vision (Circle One) HOTV SNELLEN PICTURE **Hearing (Circle One) Belltone Hear Kit**
R _____ L _____ OU _____ R _____ L _____ OU _____
With glasses? Yes ___ No ___

Development (Circle One): SCREEN DDST II PDQ NOT TESTED
Results: Untestable _____ Normal _____ Questionable _____ Abnormal _____
Comments:_____

Lab: Hgb/Hct (If indicated): Normal ☐ Abnormal☐; TB Skin Test (If Indicated): Normal ☐ Abnormal ☐

Physical exam (0=normal, X=abnormal)

Head _____ Eyes ____ Ears _____ Nose ____ Mouth _____ Teeth _____ Throat _____
Breasts ____ Lungs ____ Heart _____ Abdomen ____ Genitalia ____ Extremities ____
Neurological ____ Skin/Nodes ____
Positive findings of any medical/dental conditions needing attention: _____
_____
_____

Communicable Diseases: Tests (As Indicated)

☐ VDRL Results:_____
☐ HIV/AIDS Results:_____
☐ HEPATITIS B Results:_____
☐ OTHER Results:_____

Does child have signs or symptoms of any communicable disease(s) that would pose a significant risk of transmission in a household setting? Yes ____ No ____ Unknown____
If yes, specify disease _____

Recommendations
Additional tests:_____
Followup treatment:_____
Medications:_____
Immunizations provided:_____
Limitations on physical activity:_____
Other:_____
_____
Examining physician (Signature)_____Date_____