CHILD'S MEDICAL RECORD
FOSTER CARE

Child Care Facility: _____ Date of Examination: _____

Child's Name: _____ Sex: _____ Address: _____

Birth Term: _____ Date of Birth: _____ Birth Height: _____ Birth Weight: _____ Temp.: _____

Resp.: _____ Pulse: _____ Blood Pressure: _____ Current Height: _____ Current Weight: _____

General Appearance: _____ Abnormalities: _____ Skin: _____

Heart: _____ Lungs: _____ Eyes: _____ Ears: _____ Glands: _____ Abdomen: _____

Sight: _____ Hearing: _____ Allergies: _____ Spinal Check: _____

Feet: _____ Genitalia: _____ Rectum: _____ Other: _____

IMMUNIZATIONS

Other Immunization

Type Vaccine	Date	Date	Date	Date
DTAP or DT				
Poliomyelitis				
MMR (2 doses)				
Hib (4 doses)				
Hepatitis B (3 doses				
Chicken Pox (1 dose < 13; 2 doses 13 or over)				

TESTS

Neurological Exam (if indicated): _____ Stool Exam (if indicated): _____ Other Tests

Tests	Date	Results	
Urinalysis			
Hemoglobin			
TB Skin Test			

PREVIOUS ILLNESS (WITH AGE)

Measles: _____ Tonsillitis: _____ Diphtheria: _____

Mumps: _____ Tendency to Colds: _____ Pneumonia: _____

Whooping Cough: _____ Poliomyelitis: _____ Other: _____

CHECK ONE AND SIGN

☐ I examined this child on the above date and found the child to be free of contagious and infectious disease.

☐ I examined this child on the above date and found the child was **NOT** free of contagious or infectious disease. See reverse side for explanation.

DATE: _____ Physician's Signature: _____

ROUTINE RE-EXAMINATIONS

DATE: _____	DATE: _____	DATE: _____
Signed by Dr. _____	Signed by Dr. _____	Signed by Dr. _____

PHYSICIAN'S COMMENTS (INCLUDING HABITS, ETC.)