

**KIDS COUNT TOO, INC.**  
**Foster Care Agency**

**Child's Physical Examination**

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

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

**CHILD'S MEDICAL HISTORY**

Measles ( 7 day) \_\_\_\_\_  
Chicken Pox \_\_\_\_\_  
Rheumatic Fever \_\_\_\_\_  
Scarlet Fever \_\_\_\_\_  
Asthma \_\_\_\_\_  
Mumps \_\_\_\_\_  
Seizures \_\_\_\_\_  
Allergies \_\_\_\_\_

Broken Bone(s) \_\_\_\_\_  
Operation(s) \_\_\_\_\_  
Speech Problems \_\_\_\_\_  
Emotional Problem \_\_\_\_\_  
Physical Handicap \_\_\_\_\_  
Heart Condition \_\_\_\_\_

**IMMUNIZATION RECORD**

DPT _____	OPV _____	Measles _____
_____	_____	Rubella _____
_____	_____	Mumps _____
_____	_____	Tine Test _____
_____	_____	HIB _____

**MEDICATIONS**

Is this child on any medication? \_\_\_\_\_  
If so what? \_\_\_\_\_  
\_\_\_\_\_

**REASON SEEN TODAY:**

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

**EXAMINATION**

Height _____	Weight _____	Nutrition _____	Skin _____
Posture _____	Eyes _____	Ears _____	Nose _____
Tonsils & Adenoids _____	Teeth _____	Chest _____	Heart _____
Lungs _____	Abdomen _____	Genitalia _____	Gait _____
Neurological _____	Speech _____		

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

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

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

\_\_\_\_\_  
Date

Physician's Phone Number: \_\_\_\_\_