

FOSTER CHILD PLACEMENT MEDICAL EXAM
Geauga County Children Services

Child's Name: _____ Exam Date: _____

Birth Date: _____ Age: _____ Allergies: _____

Current Medications: _____

Illness History/concerns: _____

Height: _____ Weight: _____ Temperature: _____ Pulse: _____ Respirations: _____

BP (ages 3 years & over): _____ Hemoglobin/Hematocrit: _____ Lead screening: _____

TB test: (Date placed: _____ Date read: _____ Results: _____ mm)

*Please contact case worker with any further significant laboratory results not available during exam:

Case worker's Name: _____ **Phone:** _____

Physical Exam	Normal	Abnormal	Comment/Referral
Skin (rashes/diseases)			
Head (lice/etc)			
Eyes, ears, nose			
Mouth, teeth, pharynx			
Neck, thyroid, lymph nodes			
Chest, breasts			
Heart			
Lungs			
Abdomen			
Genitalia, anus			
Extremities, joints			
Reflexes			
Spine, trunk			

Development	Age Appropriate	Delayed	Comment/Referral
Cognitive			
Communication			
Gross & fine motor			
Self-help skills			
Social-emotional			

Other	Good	Poor	Comment/Referral
Dental			
Hearing			
Vision			
Nutrition			

Are immunizations up-to-date? Yes or No: Immunizations given today: _____

Recommendations: _____

Provider Signature: _____ Date: _____

Address: _____ Phone: _____