

CHILD'S PHYSICAL EXAM

Date Exam Scheduled: _____

Date Exam Performed: _____

Child's name: _____

Date of Birth: _____

Height: _____ Weight: _____

Temperature: _____

Blood Pressure: _____

Immunization Dates:

DPT: _____ Measles: _____

Polio: _____ Rubella: _____

Hepatitis: _____ Small Pox: _____

Chicken Pox: _____ Other: _____

Skin: _____

Scalp: _____

Adenoids: _____

Chest: _____

Glands: _____

Heart: _____

Lungs: _____

Abdomen: _____

Secondary Sex Characteristics: _____

Genitals: _____

Reflexes: _____

Extremities: _____

Posture and Spine: _____

Nutrition: _____

Signs of Endocrine Imbalance: _____

Menses: _____

Treatment given: _____

Recommendations: _____

Examining Physician Signature: _____

Please print or type: _____

(physician's name)

Address: _____

Phone: _____

I, the undersigned physician, give my permission for the foster parents to administer the following over-the-counter medications to: _____ DOB: _____

(Child's name)

Type of Drug:	Examples:	Dosage:
___ Antacids and Acid Reducers	Tums, Rolaids; generic; or _____	___ As directed on packaging or _____
___ Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7, and Vagistat-1; or _____	___ As directed on packaging or _____
___ Antihistamines	Actifed, Benadryl, Claritin, Chlor-Trimeton, Contac, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic; generic; or _____	___ As directed on packaging or _____
___ Antidiarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate; or _____	___ As directed on packaging or _____
___ Anti-fungal	Lamisil AT, Lotramin AF, and Micatin; or _____	___ As directed on packaging or _____
___ Anti-itch lotions and creams (e.g., for athlete's foot, jock itch, bug bites, poison ivy)	Bactine, Caldecort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Cortaid, Lamisil AT, Lotramin AF, and Micatin; or _____	___ As directed on packaging or _____
___ Cough Suppressants	Robitussin, Vicks 44, Chloraseptic; or _____	___ As directed on packaging or _____
___ Cold Sore/Fever Blister	Abreva Cream, Carmex; or _____	___ As directed on packaging or _____
___ Decongestant/ Nasal Decongestant and Cold Remedies	Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Sinus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Synephrine- 12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-flu, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist-1, and Triaminic; or _____	___ As directed on packaging or _____
___ Eye Drops for Allergy/Cold Relief	Ocu Hist; or _____	___ As directed on packaging or _____
___ Internal Analgesic/antipyretic	Advil, Aleve, Children's Motrin, Nuprin, Excedrin, Tylenol and Bayer; or _____	___ As directed on packaging or _____
___ Liniments	BenGay, Tiger Balm and Flexall; or _____	___ As directed on packaging or _____
___ Menstrual Cycle Medications	Midol, Pamprin, and Premysyn PMS; or _____	___ As directed on packaging or _____
___ Migraine	Advil Migraine Liqui-gels, Excedrin Migraine, Motrin Migraine Pain, or _____	___ As directed on packaging or _____
___ Pediculicide (head lice)	Nix; RID; or _____	___ As directed on packaging or _____
___ Toothache and teething pain relievers	Orajel; or _____	___ As directed on packaging or _____
___ Wart removal medications	Compound W; Tinamed or _____	___ As directed on packaging or _____

Physician Signature: _____

Please print or type: _____

(physician's name)

Address: _____

Phone: _____