CHILD'S PHYSICAL EXAM

Date Exam Scheduled: _____________(This means the date you made the phone call to schedule the appointment)
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:____
ENT (ear, nose & throat): ____
EYES:____
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 ___________________
____Anti-diarrheal 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 athletes 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 Aspirin; 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, MotrinMigraine 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: ____