CHILD'S MEDICAL 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: _____