

Please Mail Completed Report To:
Department of Children and Families
Attention:



PHYSICIAN'S REPORT ON CHILD

Name of Child: _____ Date Examined: _____

Date of Birth: _____ Height: _____ Weight: _____

GENERAL HEALTH AND PHYSICAL CONDITION: (Check if normal. Describe below if abnormal.)

☐ Eyes	☐ Mouth	☐ Abdomen	☐ Neurological
☐ Ears	☐ Circulatory	☐ Extremities	☐ Other: _____
☐ Nose	☐ Heart	☐ Genito-Urinary	_____
☐ Throat	☐ Lungs	☐ Gynecological	_____

Describe Abnormalities Noted Above: _____

Other Significant Physical Findings: _____

Recommendations for Any Above Findings: _____

History of Previous Illnesses and/or Surgery: _____

Your Evaluation of Physical and Mental Development: _____

Fill in the return address in the upper left corner (the address to which the completed form will be mailed), and the child's name and date of birth, and send the form to the examining Physician for completion.

	<u>Date</u>	<u>Result</u>
LABORATORY TESTS: Blood Test for Syphilis (or test on mother at delivery)	_____	_____
If Indicated: Urine	_____	_____
Blood Count	_____	_____
Vaginal Smear	_____	_____
Tuberculin	_____	_____
X-ray	_____	_____

How long has this child been under your care? _____

How often have you seen this child? _____

Dated this _____ day of _____, 20____

Physician's Signature

Physician's Name (print or type)

Physician's Address (print or type)