

SACRAMENTO COUNTY
 REPORT OF PHYSICAL EXAMINATION FOR CHILD IN FOSTER CARE

CASE WORKER NAME _____

CASE WORKER CODE _____ PHONE NO. _____

CASE NAME _____

PATIENT'S NAME (LAST) (FIRST) (MI) MEDICAL I.D. NUMBER

RESPONSIBLE PERSON'S NAME (LAST) (FIRST) PHONE NO.

RESPONSIBLE PERSON'S ADDRESS (STREET) (CITY) (ZIP)

PATIENT'S BIRTHDATE SEX DATE OF EXAM
 MO DAY YR F M MO DAY YR

MEASUREMENTS
 Blood Pressure
 Height: _____ Systolic / Diastolic _____ / _____
 Weight: _____ Hct / Hgb _____
 Head Circumference: _____ Birth Wt: _____
 (up to age 2 yrs.)

ASSESSMENTS	Normal	Abnormal	Not Given
Health & Development History			
Physical Examination			
Developmental Assessment			
Dental Assessment			
Nutrition Evaluation			
Vision Screening			
Audiometric Screening			
Hematocrit or Hemoglobin			
Urinalysis			
Mantoux (PPD) TB Test			
Blood Lead Test			
Chlamydia Culture*			
GC Culture*			
Pap Smear*			
Ova and Parasites*			

* only when indicated by history and physical exam
 (NAME/ADDRESS/PHONE NO. OF EXAMINING PHYSICIAN)
 (PLEASE PRINT OR TYPE)

SIGNATURE OF PHYSICIAN DATE

IMMUNIZATIONS	TYPE	Up to Date	Given	Total Since Birth	Status Unknown
	DPT/Td				
H. Flu					
Polio					
MMR					
Hepatitis B					
Varicella					
Pneumovax					
Hepatitis A **					
Influenza **					

** Risk Factor required
 Comments / Problems: If a problem is diagnosed, please enter your diagnosis in this area.

(TO BE COMPLETED BY SOCIAL WORKER)
 CHDP brochure / explanation given _____ Date _____
 CHDP Services Requested: (circle one)
 01 - Information only
 03 - Medical and Dental
 04 - Medical and Dental with scheduling and/or transportation
 05 - Medical only
 06 - Medical only with scheduling and/or transportation
 07 - Dental only
 08 - Dental only with scheduling and/ or transportation
 09 - No referral made; child under care

Return completed exam in envelope provided