Children's HOME
Empowering Families • Enriching Communities

77 Shoe House Road York, PA 17406 ● Phone (717) 755-1033 ● Fax (717) 755-9993

RESOURCE FAMILY – MEDICAL EXAMINATION FORM FOR CHILDREN 0-23 MONTHS

NAME:_____ DOB: _____ DATE OF EXAM:_____

1. Does the child have a history of any of the following:
   a. Serious illness if so please list_____
   b. Broken bones if so please list_____
   c. Allergies if so please list _____
   d. Operations if so please list _____
   e. Hospitalizations if so please list_____
2. Does the child take any medication? If so please list
   _____
3. Last date of: TB Test: _____ DT Booster: _____Polio: _____
   Rubella Status: _____Hep. B: (1)_____ (2)_____ (3)_____
   Haemophilus Influenza Type B (HIB) _____Varicella Vaccine (Chicken Pox) _____
   Sickle Cell results: _____ Test Date: _____ Conducted by: _____
4. Review of systems: Temp: _____ Pulse: _____ Respiration_____ B/P: _____

Height: _____ Weight: _____lbs _____oz Appetite: _____
Oriented to Person: _____ Place_____ Time_____ Race_____
Characteristic Markings: _____ Eye Color_____ Hair Color_____
Hearing_____Bruises_____Lesions_____Rash_____

General Appearance:	NORMAL	ABNORMAL	COMMENTS
Skin	_____	_____	
HEENT	_____	_____	
Dental	_____	_____	
Neck (Thyroid)	_____	_____	
Lymph Nodes	_____	_____	
Chest (Breasts)	_____	_____	
Heart	_____	_____	
Abdomen	_____	_____	
Genitalia/Hernia	_____	_____	
Extremities	_____	_____	
Orthopedic (Spine)	_____	_____	
Neurological	_____	_____	
Mental Status	_____	_____	

GENERAL IMPRESSIONS: RECOMMENDATIONS:

Physician_____ Nurse_____ Date _____