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) MEDI-CAL I.D. NUMBER

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

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

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

MEASUREMENTS

Height: _____ Blood Pressure 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

(CS 343 Revised 5/02)

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