

Foster Care Initial Health Evaluation

		DATE OF EXAMINATION
CHILD'S NAME (LAST, FIRST, MIDDLE INITIAL)		DATE OF BIRTH
BROUGHT IN BY (NAME): <input type="checkbox"/> Social Worker <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other:		CONTACT TELEPHONE NUMBER
ALLERGIES	WEIGHT (LBS)	PERCENTILE
	HEIGHT (FT/IN)	PERCENTILE
IMMUNIZATION STATUS REVIEWED	BLOOD PRESSURE	TEMPERATURE

What is the source of medical information you used during this visit?

- Medical Records Child Information Form None Comprehensive Health Report Child Case Worker
 Foster Parent Other:

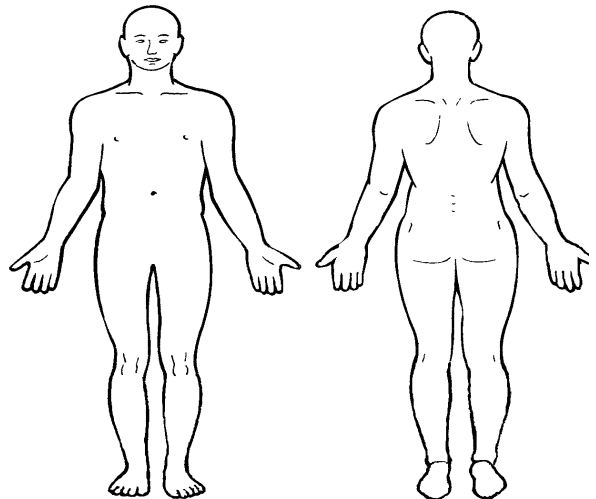
Child has medical history of:

- Asthma Seizures Developmental Delay Sexually Active Diabetes Substance Abuse
 Other (List):

Does the child have physical signs or symptoms compatible with abuse or neglect? Yes No

PHYSICAL:	N	A		N	A
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>
Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Gait	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>			

Use this area to show any marks bruises and/or scars.



Describe Abnormal Findings:

Anticipatory counseling given to foster parents about expected behaviors:

- Sleep Disorders Appetite Change Voiding Issues Behavior/Anger/Impulsive Grief/Loss
 Birth Family Contact Concerns

Additional Comments:

Assessment/Plan of Care for this child will be: (Check all that apply)

- Referrals: Dental Substance Abuse Mental Health Subspecialist
 Other (List)

Schedule EPSDT/Well Child

CLINICIAN

TELEPHONE NUMBER

DISTRIBUTION: Original – Physician Yellow – DSHS Pink – Foster Parent/Guardian