Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

Foster Care Initial Health Evaluation

DATE OF EXAMINATION	
CHILD'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH
BROUGHT IN BY (NAME): ☐ Social Worker ☐ Foster Parent ☐ Other:	CONTACT TELEPHONE NUMBER

ALLERGIES	WEIGHT (LBS)	PERCENTILE
	HEIGHT (FT/IN)	PERCENTILE
IMMUNIZATION STATUS REVIEWED	BLOOD PRESSURE	TEMPERATURE

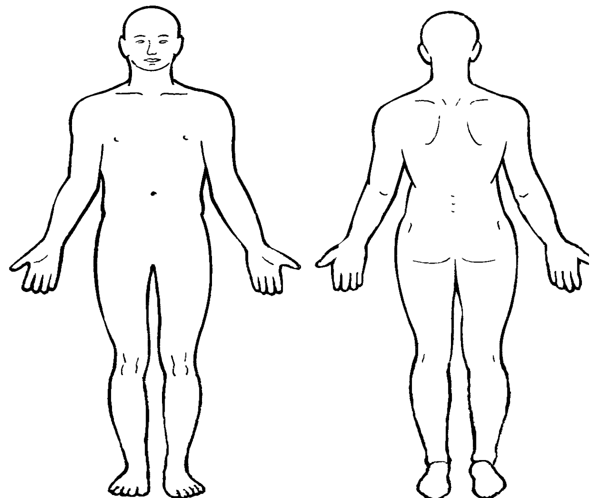
What is the source of medical information you used during this visit?
☐ Medical Records ☐ Child Information Form ☐ None ☐ Comprehensive Health Report ☐ Child ☐ Case Worker
☐ Foster Parent ☐ Other:

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	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Neurological	☐	☐
Nodes	☐	☐	Gait	☐	☐
Mental Health	☐	☐			

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



Describe Abnormal Findings:

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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