TRY-AGAIN HOMES, INCORPORATED
CHILD'S INITIAL AND PERIODICAL MEDICAL EXAMINATION FORM

This examination is requested by Try-Again Homes, Inc. to determine the health of the child in respect to placement in a foster home. This medical information is for the use of Try-Again Homes, Inc. only.

Child's Name: _____ Birth date: _____

Any particular complaint? _____

_____

Height: _____ Weight: _____ Skin: _____

Scalp: _____ Nose: _____ Teeth: _____

Eyes- Right: _____ Ears – Right: _____

Left: _____ Left: _____

Tonsils: _____ Adenoids: _____ Glands: _____
Chest: _____ Heart: _____ Lungs: _____
Abdomen:_____ Genitals: _____ Extremities: _____
Spine: _____ Reflexes: _____ Blood Pressure: _____

Communicable Diseases: _____ Yes _____ No
If yes, please note: _____

_____

Nervous Disorders: _____

Sexual Development: _____

Nutrition: _____

If tests or immunizations given at this time, specify type and results:

_____

_____

Medication Prescribed: _____

Recommendations: _____

_____

Physician's Signature: _____ Date: _____

Note to Physician: Please submit this completed form directly to:

Name: _____
Try-Again Homes, Inc.
PO Box 1228
Washington, PA 15301