CHILD'S INITIAL AND PERIODICAL MEDICAL EXAMINATION

THIS EXAMINATION IS REQUESTED BY TRY-AGAIN HOMES INCORPORATED 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: _____ D.O.B.: _____

ANY PARTICULAR COMPLAINT? _____

HEIGHT: _____ WEIGHT: _____ SKIN: _____
SCALP: _____ NOSE: _____ TEETH: _____
EYES- R: _____ EARS –R: _____
L: _____ L: _____
TONSILS: _____ ADENOIDS: _____ GLANDS: _____
CHEST: _____ HEART: _____ LUNGS: _____
ABDOMEN: _____ GENITALS: _____ EXTREMITIES: _____
SPINE: _____ REFLEXES :_____ BP: _____

NERVOUS DISORDERS: _____
SEXUAL DEVELOPMENT: _____ SEROLOGY: _____

IF TEST OR IMMUNIZATIONS GIVEN AT THIS TIME, SPECIFY TYPE AND RESULTS:

_____
MEDICATION PRESCRIBED: _____
RECOMMENDATIONS: _____
_____

PHYSICIAN'S CONTACT INFORMATION:

NAME: _____
ADDRESS: _____
_____
TELEPHONE/FAX: ( ) _____ ( ) _____

_____
(PHYSICIAN'S SIGNATURE/DATE)

PLEASE SUBMIT THIS COMPELTED FORM DIRECTLY TO:
TRY-AGAIN HOMES, INCORPORATED
103 EUCLID DRIVE
PARKERSBURG, WV 26102