MEDICAL EXAMINATION FORM - INSTRUCTIONS

Please refer to the CONSENT & MEDICAL RECORD PROCEDURES FOR FOSTER CAREGIVERS on the reverse side of this form.
(To **be completed by CSW/Caregiver. Please** print **legibly.)**

☐ Infants (0-36 months) or "High Risk" children must be medically examined within ten (10) days of initial placement, or sooner if medically required or recommended. "High Risk" includes one or more of the following conditions exists: a past or present significant medical problem or chronic illness; possible contagious disease; on medication; and/or a social problem (e.g., language barrier) which might conceal an unmet medical need.

☐ Child must have medical exam within thirty (30) days of initial placement.

☐ Child needs annual/age-appropriate medical exam by _____

CHILD's NAME: ..... DOB: ..... CASE#: ..... DATE PLACED: .....

CAREGIVER: _____ (Phone) _____ (FFA) _____ (Phone._' _____

CSW: _____ (File#) _____ (Phone) _____ (Fax) _____

Medical data entered into **CWS/CMS by: (Name)** _____ **(Date)** _____

MEDICAL EXAMINATION FORM (To be completed by Doctor.)

PHYSICAL EXAMINATION

PLEASE SEE PAGE 2 FOR DEVELOPMENTAL SCREENING DOCUMENTATION

Doctor is a CHOP provider? ☐ Yes ☐ No Was child tested for lead poisoning? ☐Yes ☐ No

Date of Physical Examination: _____ Name of Doctor:

☐Initial CHOP/CHOP-equivalent examination.
☐Annual/age-appropriate CHOP/CHOP-equivalent examination.
☐Other/Follow-up visit.
☐Doctor's own exam form or PM 160 attached.
If not attached, complete below.

☐Condition and treatment were explained to the caregiver and child/youth {as age appropriate).
☐Youth may self administer hls/her own medication with adult supervision.
☐Youth Is authorized to self administer his/her own medication.

Physical Exam results: Age: (Yrs.): {Mos.): (Wks.) Height: % **Weight:** %
Body Mass Index **(BMI)** Score: Body Mass Index%:
(May be continued on additional pages in necessary. If so, provider musl date and sign second page.)

_____ _____
(Treatment given; Medications Prescribed. Please attach copies of supporting documentation; test results. etc.)

_____

_____

If follow-up care Indicated, specify: _____

Immunizations given: _____
(If appropriate, complete immunization Record)

Signature of Health Care Provider: _____,,.(Date) _--,--,----
(Doctor, Nurse Practitioner. Physician's Assistant)

Address: _____ Phone: _____

(Signature Stamp Required)

CONSENT (Caregiver Is a Foster Parent. Relative, Group Home, or FFA).

DCFS 561(a)(Rev.1/2017) MEDICAL EXAMINATION FORM

Leave several forms With the caregiver when the child Is Initially placed.

Make photocopy of completed/signed original and provide photocopy to caregiver. File the completed/signed original In the Psychologlcal/MedlcaUDental fo der.

***DEVELOPMENTAL SCREENING INFORMATION** (to be completed by Health Care Provider)

- Developmental Screening Completed?: ☐Yes ☐No Developmental Screen Concerns?: ☐Yes ☐No
- If Yes, what type: ☐Ages & Stages Questionnaire
  ☐PEDS
  ☐Denver Developmental Screen
  ☐Other:_____
- Developmental Screen Comments:._____

FOR STAFF USE ONLY

Conclusion/Follow Up:

Print Name	*Signature*	*Date and Time*

Supervisor's Remarks (including administrative follow-up):

Print Name	*Signature*	*Date and Time*

Distribution:

	Name of Person Contacted	*Telephoned (Date)*	*E-mail/Mail/Fax (Date)*
Parent(s)/Guardian			
County Worker			
Licensing			
Monitor			
Child Abuse Report			
Police Department Report No.			
Copy for Home File			
Other:			