

### 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 his/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 must date and sign second page.)

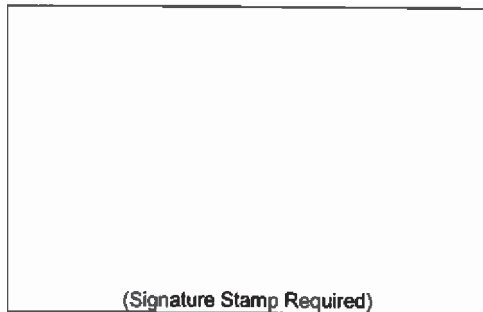
\_\_\_\_\_  
(Treatment given; Medications Prescribed. Please attach copies of supporting documentation; test results. etc.)

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: \_\_\_\_\_



### 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 Psychological/Medical/Dental folder.

**\*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:*

<i>Print Name</i>	<i>Signature</i>	<i>Date and Time</i>

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

<i>Print Name</i>	<i>Signature</i>	<i>Date and Time</i>

*Distribution:*

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