CHESTER COUNTY DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES
GOVERNMENT SERVICES CENTER, SUITE 310
601 WESTTOWN ROAD WEST CHESTER, PA 19382-4526
(610-344-5800)

USE FOR CHILDREN 3 AND OVER

PHYSICIAN'S REPORT

CHILD'S NAME:_____ D.O.B.:_____ EXAM DATE: _____

		NORMAL	ABNORMAL
HEIGHT: WEIGHT:			
SCALP:			
SKIN:			
EYES:	RIGHT		
	LEFT		
NOSE:			
MOUTH:	TEETH		
	CAVITIES		
THROAT, TONSIL:			
SPEECH:			
NECK:	THYROID		
	CERVICAL GLANDS		
ANATOMICAL STIGMATA:			
NERVOUS DISORDERS:			
CHEST:			
LUNGS:			
HEART:	MURMUR		
	RATE		
	BLOOD PRESSURE		
ABDOMEN:	LIVER		
	SPLEEN		
	KIDNEYS		
GENITO URINARY:	BLADDER		
	URINATION		
	GENITALS		
	INGUINAL GLANDS		
ORTHOPEDIC CONDITION:	SHOULDERS		
	SPINE		
	HIPS		

IMMUNIZATIONS OR VACINATIONS OR PRESCRIPTIONS GIVEN AT THE TIME OF EXAM: _____

SHOULD THIS CHILD HAVE ANY RESTRICTIONS ON HIS PHYSICAL ACTIVITIES (IF YES, PLEASE ELABORATE):

IS THIS CHILD FREE FROM COMMUNICABLE DISEASE: YES _____ NO _____

SHOULD DCYF INSURE THE CHILD HAS A FURTHER EVALUATION BY A SPECIALIST (IF YES, IDENTIFY TYPE OF SPECIALIST):

EXAMINING PSYSICIAN: _____

ADDRESS: _____ PHONE:_____

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USE FOR CHILDREN
UNDER 3 YEARS

PHYSICIAN'S REPORT

CHILD'S NAME:_____ **D.O.B.:**_____ **EXAM DATE:** _____

HEIGHT:_____ **WEIGHT**_____ **LBS.** _____ **OZS.**

CIRCUMFERENCE OF HEAD: _____

CIRCUMFERENCE OF CHEST:_____

FONTANELLE:_____

CROWN TO RUMP:_____

SKIN: _____

HEART AND LUNGS:_____

ABDOMEN: _____

GENITALIA:_____

EXTREMITIES:_____

IMMUNIZATIONS OR VACCINATIONS GIVEN AT TIME OF EXAM:_____

_____

_____

DIAGNOSIS:_____

_____

_____

TREATMENT:_____

_____

_____

RECOMMENDTIONS:_____

_____

CHILD SHOULD RETURN IN:_____

CONSULTATION DESIRED WITH SOCIAL WORKER: _____

EXAMINING PHYSICIAN: _____

ADDRESS:_____ **PHONE:**_____

(PLEASE GIVE FORM TO CASEWORKER, FOSTER MOTHER, DEPARTMENT DRIVER OR MAIL TO DCYF.)

REVISED 11/30/06/jp