PTS PARKER THERAPEUTIC SERVICES

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# Medical Examination Report

Resource Parent's Name: _____

| Patient's Name: | | Date of Exam: |
|---|---|---|
| Weight: | | Height: |
| Age: | Gender: | Period Under Care: |

## Physical Examination

| Vision: | Hearing: |
|---|---|
| Nose: | Teeth: |
| Throat: | Skin: |
| Heart: | Lungs: |
| Blood Pressure: | Pulse: |
| Abdomen: | Extremities: |
| Comments: | |

## Tests: Has the patient had any of the following in the past year?

***TB test (via Tine or Chest X-Ray MUST be Completed on EACH Household Member for Licensure)***

| Test | Yes | No | Date | Result |
|---|---|---|---|---|
| TB (Tine) | | | | |
| Chest X-Ray | | | | |
| STS | | | | |
| CBC | | | | |
| Urine Analysis | | | | |

***Additional Comments***:

_____
_____
_____
_____
_____
_____.

## MEDICAL REPORT FOR ALL HOUSEHOLD MEMBERS OF THE FOSTER FAMILY (including applicant/s)

Name of Patient: _____ Date of Exam: _____

Name of Resource Parent: _____ Relationship: _____

List any medical illnesses that this individual has been treated for in the past two (2) years:

_____
_____

Has this individual ever been treated for drug or alcohol abuse? If yes, please explain.

_____
_____

Is there any reason why a foster child should not be placed in the same home as this patient? If yes, please explain.

_____
_____
_____

Additional Comments:

_____
_____

……

I certify that _____ is free of communicable/infectious disease.

_____ _____

Signature of Examining Physician Date Signed

Typed/Printed Name: _____

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Office Hours
Monday - Friday
9:00am - 6:00pm