



**THERAPEUTIC FOSTER CARE  
EXAMINATION FORM**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Check Appropriate Box:     Physical Exam     Dental Exam     Eye Exam

**PHYSICAL EXAM:** (Check box if normal. Explain if any evidence of abnormality.)

- Vision \_\_\_\_\_
- Hearing \_\_\_\_\_
- Heart \_\_\_\_\_
- Lungs \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Kidneys \_\_\_\_\_
- Other \_\_\_\_\_

(Attach Laboratory Reports as applicable)

**GENERAL CONDITION (detailed)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current Medications \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Physician Name (printed)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address

(This form may be used by the Physician in lieu of a narrative or other type report form.)