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| **It is important that a complete Medical Record is kept on each child in care. We would kindly ask you to complete the top part of this form and sign at the bottom every time you examine or treat a child in care, whether at home, in your office or at hospital.** | | | | |
| Child’s Name: | | Birthdate: | | |
| Date of Examination: | | Health Card #: | | |
| Accompanied by: (list all those who accompanied the child/youth to the appointment): | | | | |
| CAS Worker’s Name: | | | | |
| **Provisional Diagnosis:** | | | | |
| **Treatment Prescribed:** | | | | |
| **Document the Child’s Concerns (for any medication change):** | | | | |
| **SECTION BELOW ONLY TO BE COMPLETED FOR INTAKE MEDICALS AND ANNUAL PHYSICALS** | | | | |
| Height: | Weight: | Blood Pressure: | | |
| Nutritional State: | | Teeth: | | Nose: |
| Eyes (vision): | | Ears: | | |
| Hearing: | | Throat: | | |
| Neck-Lymph Nodes: | | Abdomen-Thoracic Cage: | | |
| Heart: | | Nervous System Development: | | |
| Lungs: | | Thyroid: | | |
| Reflexes: | | Glands: | | |
| Abdomen-Liver: | | Genitals: | | |
| Skin Condition (birth marks, etc.): | | Extremities and Skeletal System: | | |
| **RECOMMENDATIONS:** | | | | |
| **Physician’s Name:** | | | **Telephone #:** | |
| **Physician’s Address:** | | | | |
| **Physician’s Signature:** | | | **Date:** | |