



**GROUP HOME, INSTITUTION
CHILD PHYSICAL EXAMINATION HEALTH RECORD**

State Form 49964 (R2 / 4-14)

Name of child	Date of birth (month, day, year)
Address (number and street, city, state, and ZIP code)	

MEDICAL HISTORY

I. LIST PAST HOSPITALIZATIONS / OPERATIONS / ACCIDENTS:	
II. COMMUNICABLE DISEASES	
	MONTH / YEAR
Measles	_____
Rubella (<i>German Measles</i>)	_____
Chicken Pox	_____
Mumps	_____
Scarlet Fever	_____
Whooping Cough	_____
Other _____	_____
_____	_____
III. CONDITIONS (<i>PLEASE EXPLAIN IF PRESENT</i>)	
Allergies:	
Physical Defects:	
Use of any Drugs / Medication:	
Why:	
Other:	
IV. Note any exposure to communicable disease within the past three weeks, if yes explain:	

PHYSICAL EXAMINATION

I. Skin _____	Heart _____
Lymphnodes _____	Blood Pressure _____
Eyes _____	Lungs _____
Vision _____ R _____ L _____	Abdomen _____
Ears _____	Genitalia _____
Hearing _____ R _____ L _____	Skeleton _____
Nose & Throat _____	Other _____
Teeth & Mouth _____	_____

State of development _____

* Please note any unusual findings: _____

HISTORY OF IMMUNIZATIONS AND TESTS (Indicate month / year)

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DTP/Td	HPV*																
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Hepatitis B Vaccine	Measles Mumps Rubella																
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Varicella	Tdap																
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III. Mantoux TB skin test	Date (month, day, year)	Result
Chest X-ray if above skin test is positive.	Date (month, day, year)	Result

Other laboratory test as ordered by physician _____

IV. Does this person have any health condition that would be hazardous either to them or to children in a group setting as a result of participation in normal activities (including sports)?
 Yes No

If yes, what modification of normal activities is necessary?

V. Have you prescribed any medications and /or special routines (such as diet) which should be included in planning this person's activities?
 Yes No

Explain:

Date of exam (month, day, year)	Signature of physician
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* HPV is recommended, but not required.