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 (*German Measles*)	
Chicken Pox	
Mumps	
Scarlet Fever	
Whooping Cough	
Other	

III. CONDITIONS (*PLEASE EXPLAIN IF PRESENT*)

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 _____

R L

Hearing _____ _____ _____ Skeleton _____

Nose & Throat _____ Other _____

Teeth & Mouth _____

State of development

* Please note any unusual findings:

HISTORY OF IMMUNIZATIONS AND TESTS (*Indicate month / year*)

II.

DTP/Td: 1 | 2 | 3 | 4 | 5

Polio: 1 | 2 | 3 | 4

Hepatitis B Vaccine: 1 | 2 | 3

Varicella: 1 | 2 or date of disease _____ month/year

HPV*: 1 | 2 | 3

MCV4: 1 | 2

Measles Mumps Rubella: 1 | 2

Tdap: 1

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

* HPV is recommended, but not required.