



# MEDICAL REPORT

- Annual Physical (\*\*please send copy of Texas Health Steps exam form\*\*)  
 Dental  Eye Exam  Sick Visit  
 OB/GYN  Other \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_

ATTENDING FOSTER PARENT \_\_\_\_\_

PHYSICIAN'S COMPLETE NAME \_\_\_\_\_

Medical clinic address \_\_\_\_\_  
Address City, State, Zip

Medical clinic phone number \_\_\_\_\_

☺ DATE AND TIME \_\_\_\_\_

\*\*REASON FOR EXAMINATION \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

EXAMINATION RESULTS (include diagnosis and/or referral) \_\_\_\_\_

RECOMMENDED TREATMENT/PRESCRIBED MEDICATION \_\_\_\_\_

Follow-up Referrals: \_\_\_\_\_

### LIMITATIONS TO CHILD:

Is there any medical reason why this child cannot be involved in any of the following?

\_\_\_\_\_ Administration of psychotropic medication

\_\_\_\_\_ Participation in sports, recreation, or work activity requiring physical exertion

\_\_\_\_\_ OTHER: specify \_\_\_\_\_

PLEASE EXPLAIN ANY LIMITATIONS \_\_\_\_\_

Doctor would like to see this child again on \_\_\_\_\_ at \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_