Athens County Children Services

MEDICAL REPORT

Name of Child ______________________________ **Date of Visit** ______________________________

Check One:

Annual Well Child Exam: Ill Child Exam: Follow-up Visit: Emergency: Specialist Visit:

TEMPERATURE	PULSE	RESPIRATION	BLOOD PRESSURE	WEIGHT	HEIGHT

Reason for visit:

Patient is allergic to:

Patient is currently taking the following medication:

Any Immunizations or Boosters given today? Yes____No ___ If YES, please provide record to Foster Parent

Any test run today? Yes___ No____ If YES, please send results to Foster Parent

Treatment Recommended, if any:

Medication Prescribed and Reason for Medication

IF COMPLETING AN ANNUAL EXAM, PLEASE FILL OUT

ITEM	NORMAL	ABNORMAL	NOT DONE	DESCRIBE ABNORMALITY
VISION SCREENING				Rt: Left:
HEARING SCREENING				Rt: Left:
EYE, EARS, NOSE, THROAT				
NECK				
CHEST				
LUNGS				
HEART				
ABDOMEN				

____
Doctor's Name (please print)

____
Signature of Doctor

____
Address
____

____
Phone number