

LoneStar Solutions Foster Care
Initial/Annual Physical Exam

Name: _____ DOB: _____ Age: _____ Date Admitted: _____
SS#: _____ Medicaid #: _____ Foster Parent: _____

Date of Exam: _____ Physician's Name: _____
Physician's Address: _____
Physician's Telephone #: _____

Current medical concerns: _____

Current medications, prescribing physician, dosage, etc:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Known allergies: _____

Exam results: (to be filled out by physician)

Height: _____ Weight: _____ Ears: _____ Eyes: _____

Heart: _____ Lungs: _____

Skin: _____ Digestive: _____

Limbs/Muscle Tone: _____

Genital: _____ Other: _____

TB Test Given: _____ Results: _____ Date Read: _____

Immunizations Needed: _____

Immunizations Given: _____

Does the child appear to have any contagious disease? Yes No Explain the treatment
needed, if any: _____

Please note any area of concern, and the follow-up or referral needed: _____

Please provide orders for over-the-counter medications that can be given to this child.

Physician Signature: _____ Date: _____