



REPORT OF PHYSICAL EXAMINATION FOR CHILD IN FOSTER CARE

Please complete form and send to:
 V.B.R. Family & Children Resource Agency
 1852 W. Eleventh Street, Suite 699
 Tracy, CA 95376

CASE NAME	CASE WORKER NAME
CASE WORKER CODE	PHONE NUMBER

PATIENTS NAME (LAST) (FIRST) (MIDDLE)	MEDICAL ID NUMBER
RESPONSIBLE PERSON'S ADDRESS (STREET) (CITY) (ZIP)	

PATIENT'S BIRTHDAY			SEX		DATE OF EXAM		
MONTH	DAY	YEAR	FEMALE	MALE	MONTH	DAY	YEAR

MEASUREMENTS	
HIEGHT:	BLOOD PRESSURE:
WEIGHT:	SYSTOLIC DIASTOLIC: /
BIRTH WEIGHT:	HCT/HGB: /
HEAD CIRCUMFERENCE (UP TO AGE 2 YRS):	

IMMUNIZATIONS				
TYPE	UP TO DATE	GIVEN	TOTAL SINCE BIRTH	STATUS UNKNOWN
DPT/Td				
H. Flu				
Polio – Oral or IPV				
Measles				
Mumps				
Rubella				
Hepatitis B				

DENTAL EXAM

State of California regulations mandate that all foster children over the age of two are required to have an examination by a licensed dentist within three months after placement into a foster home. Thereafter, semi-annually checkups are also required.

Please document the results of your exam, detail the specific treatment(s) you administered, sign, date, and return to:

**V.B.R. Family & Children Resource Agency
1852 W. Eleventh Street, Suite 699
Tracy, CA 95376**

Phone: 209-830-6394 / Fax: 209-833-8386

CHILD'S NAME:	
SPECIFIC FINDINGS AND TREATMENT:	
DENTIST'S NAME:	
DENTIST'S ADDRESS:	
DENTIST'S PHONE NUMBER:	
SIGNATURE:	
DATE:	