H.O.P.E
Helping Others Prosper Everyday

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FOSTER CHILD HEALTH EXAM AND TB TEST

Name of Foster Child: _____

Name of Physician: _____
Address of Physician: _____
Phone Number of Physician: _____

Date of Physical Exam: _____

PHYSICIAN USE ONLY:
Allergies:

_____
_____
_____

Diseases:

_____
_____
_____

Chronic or Frequent Symptoms:

_____
_____
_____

Urinalysis: _____
Blood Pressure: _____
Height: _____
Weight: _____

Vision:
Left Eye _____
Right Eye _____

TB Test given on: _____

Results read on: _____
Results: ☐ **Positive** ☐ **Negative**

_____ _____
Physician Signature **Date**

_____
Printed Name