



_____, Florida

PHYSICIAN'S REPORT ON CHILD

Name of Child _____

Date Examined _____

Date of Birth _____ Height _____

Weight _____

GENERAL HEALTH AND PHYSICAL CONDITION: (Check if normal. Describe below if abnormal)

- Eyes
- Ears
- Nose
- Throat
- Mouth
- Circulatory
- Heart
- Lungs
- Abdomen
- Extremities
- Genito-Urinary
- Gynecological
- Neurological
- Other _____

Describe Abnormalities Noted Above _____

Other Significant Physical Findings _____

Recommendations for Any Above Findings _____

History of Previous Illness and/or Surgery _____

Your Evaluation of Physical and Mental Development _____

	<u>Date</u>	<u>Result</u>
LABORATORY TESTS: Blood Test for Syphilis (or test on mother at delivery)	_____	_____

- If Indicated:
- Urine
 - Blood Count
 - Vaginal Smear
 - Tuberculin
 - X-ray

How long has this child been under your care? _____

How often have you seen this child? _____

Dated this _____ date of _____, 20 _____

Physician's Signature

Physician's Name (Print or Type)

Physician's Address (Print or Type)