WHIMSPIRE
Youth Health Evaluation/Annual Physical

Dear Physician:

The completion of this statement is necessary for this child to be cared for in a Family Care Home.

YOUTH NAME:________________________________DOB:____________________________________

Address: ____

Tuberculin Testing: Date given: _________________Result: _____________________N/A ________

Chest X-rays: _________________ Result: _____________________ N/A ________

SURGERY, ACCIDENTS, ILLNESS, CHRONIC OR HANDICAPPING PROBLEMS:

____

____

____

NEED FOR MEDICAL OR SPECIAL DIETS: ____

USE OF NON-PRESCRIPTION MEDICATION

___________________________ may be given the following non-prescription medications when needed:
Child's Name

Tylenol or ______________________________________ in the dosage of ___________________________
(other medication)

for the purpose of ____

Sudafed or ______________________________________ in the dosage of ___________________________
(other medication)

for the purpose of ____

____ in the dosage of __________________________________

for the purpose of ____

THESE RECOMMENDATIONS SHOULD BE UPDATED YEARLY

IMMUNIZATIONS: DATE OF COMPLETED PRIMARY OR LATEST BOOSTER:

TYPE: ____________ *DATE:* ______________ *TYPE:* ______________ *DATE:* ______________

TYPE: ____________ *DATE:* ______________ *TYPE:* ______________ *DATE:* ______________

PHYSICAL FINDING (INCLUDE, IF TESTED VISION AND HEARING):

____

____

COMMENTS/RECOMMENDATIONS TO FAMILY FOSTER PARENTS:

____

____

DOCTOR'S PRINTED NAME:____

DOCTOR'S SIGNATURE: ____

DOCTOR'S ADDRESS: ____

PHONE**:** ____________________

DATE:______________________