

TRY-AGAIN HOMES INCORPORATED  
West Virginia Specialized Foster Care  
Medical Report on Bio-Children in Foster Home

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ANY PARTICULAR COMPLAINT? \_\_\_\_\_

HEIGHT: _____	WEIGHT: _____	SKIN: _____
SCALP: _____	NOSE: _____	TEETH: _____
EYES - RIGHT: _____	EARS - RIGHT: _____	
EYES - LEFT: _____	EARS - LEFT: _____	
TONSILS: _____	ADENOIDS: _____	GLANDS: _____
CHEST: _____	HEART: _____	LUNGS: _____
ABDOMEN: _____	GENITALS: _____	EXTREMITIES: _____
SPINE: _____	REFLEXES: _____	BLOOD PRESSURE: _____
TB Test: _____		

NERVOUS DISORDERS: \_\_\_\_\_

SEXUAL DEVELOPMENT: \_\_\_\_\_ SEROLOGY: \_\_\_\_\_

NUTRITION: \_\_\_\_\_

IF TESTS OR IMMUNIZATIONS GIVEN AT THIS TIME SPECIFY TYPE AND RESULTS:

\_\_\_\_\_

MEDICATION PRESCRIBED: \_\_\_\_\_

RECOMMENDATIONS: \_\_\_\_\_

\_\_\_\_\_

PHYSICIAN'S NAME AND ADDRESS:

\_\_\_\_\_  
(PLEASE PRINT)  
\_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_

\_\_\_\_\_  
(PHYSICIAN'S SIGNATURE/DATE)