TRY-AGAIN HOMES INCORPORATED
CHILD'S INITIAL AND PERIODICAL MEDICAL EXAMINATIONS

THIS EXAMINATION IS REQUESTED BY TRY-AGAIN HOMES, INC. TO DETERMINE THE HEALTH OF THE CHILD IN RESPECT TO PLACEMENT IN A FOSTER HOME. THIS MEDICAL INFORMATION IS FOR THE USE OF TRY-AGAIN HOMES, INC. ONLY.

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:_________

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)

NOTE TO PHYSICIAN: PLEASE SUBMIT COMPLETED FORM TO:
TRY-AGAIN HOMES INCORPORATED
1800 LOCUST AVENUE
FAIRMONT, WV 26554