Benchmark Family Services

Fort Wayne Regional Office
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Medical Appointment Form

All Foster Children are required to have Annual EPSDT Physicals to meet State standards.
*****Please complete the attached INDIANA STATE FORM 49964 if the visit is for a physical exam.*****

Child's Name: _____ DOB: _____

Date of Appointment: _____

Providers Name: _____

Address: _____

_____

Phone/Fax#: _____

Type of Appointment:

Annual EPSDT Physical Exam: ☐ Sick Visit: ☐ Hearing Screening (EPSDT): ☐
Follow-Up Visit: ☐ Other: ☐ Vision Screening (EPSDT): ☐

Examination Notes and Treatment Recommendations:

_____

_____

_____

_____

Medication Prescribed	Dosage	Time of Day	Possible Side Effects of the Medications

Signature of Provider: _____ Date: _____

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Revised: 6/13/06 CSC; 3/27/09; 5/14/09

GROUP HOME, INSTITUTION
CHILD PHYSICAL EXAMINATION HEALTH RECORD
State Form 49964 (R2 / 4-14)

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Name of child	Date of birth (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)	

MEDICAL HISTORY

I. LIST PAST HOSPITALIZATIONS / OPERATIONS / ACCIDENTS:

II. COMMUNICABLE DISEASES

	MONTH / YEAR
Measles	
Rubella (*German Measles*)	
Chicken Pox	
Mumps	
Scarlet Fever	
Whooping Cough	
Other	

III. CONDITIONS (*PLEASE EXPLAIN IF PRESENT*)

Allergies:

Physical Defects:

Use of any Drugs / Medication:

Why:

Other:

IV. Note any exposure to communicable disease within the past three weeks, if yes explain:

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PHYSICAL EXAMINATION

I. Skin _____ Heart _____

Lymphnodes _____ Blood Pressure _____

Eyes _____ Lungs _____

Vision _____ R _____ L _____ Abdomen _____

Ears _____ Genitalia _____

R L

Hearing _____ _____ _____ Skeleton _____

Nose & Throat _____ Other _____

Teeth & Mouth _____ _____

State of development

* Please note any unusual findings:

HISTORY OF IMMUNIZATIONS AND TESTS (*Indicate month / year*)

II.

	1	2	3	4	5
DTP/Td					

	1	2	3
HPV*			

	1	2	3	4
Polio				

	1	2
MCV4		

	1	2	3
Hepatitis B Vaccine			

	1	2
Measles Mumps Rubella		

	1	2		month/year
Varicella			or date of disease	

	1
Tdap	

III.		
Mantoux TB skin test	Date *(month, day, year)*	Result
Chest X-ray if above skin test is positive.	Date *(month, day, year)*	Result

Other laboratory test as ordered by physician

IV. Does this person have any health condition that would be hazardous either to them or to children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No

If yes, what modification of normal activities is necessary?

V. Have you prescribed any medications and /or special routines (*such as diet*) which should be included in planning this person's activities?

☐ Yes ☐ No

Explain:

Date of exam *(month, day, year)*	Signature of physician

* HPV is recommended, but not required.

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