

**FREE TO BE PROGRAMS
PHYSICAL EXAMINATION**

RESIDENT/CLIENT INFORMATION (To be completed by certified parent or social worker)

NAME:		TELEPHONE:		
ADDRESS:	NUMBER	STREET	CITY	ZIP
DIAGNOSIS:				
AGE:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		

MEDICAL INFORMATION (To be completed by physician)

DATE OF EXAMINATION:			
HEIGHT	%	WEIGHT	%
BLOOD PRESSURE:		PULSE:	
IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? <input type="checkbox"/> Yes <input type="checkbox"/> No			
TUBERCULOSIS EXAMINATION RESULTS:		DATE OF LAST TB TEST	
OTHER CONTAGIOUS/INFECTIOUS DISEASES:		TREATMENT MEDICATION: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
ALLERGIES:		TREATMENT MEDICATION: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
SEIZURE DISORDER: <input type="checkbox"/> Yes <input type="checkbox"/> No		TREATMENT MEDICATION: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
AMBULATORY STATUS: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Nonambulatory			
IMMUNIZATIONS GIVEN: <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, LIST:	
LAB WORK ORDERED:			

REFERRALS/RECOMMENDATIONS:

Signature of Health Care Provider _____ Date _____

Please print or stamp the name, address and phone number of the physician/office below.