**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:  🞏 Male 🞏 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? 🞏 Yes 🞏 No

TUBERCULOSIS EXAMINATION RESULTS: DATE OF LAST TB TEST

OTHER CONTAGIOUS/INFECTIOUS DISEASES: TREATMENT MEDICATION: 🞏 Yes 🞏 No 🞏 N/A

ALLERGIES: TREATMENT MEDICATION: 🞏 Yes 🞏 No 🞏 N/A

SEIZURE DISORDER: 🞏 Yes 🞏 No TREATMENT MEDICATION: 🞏 Yes 🞏 No 🞏 N/A

AMBULATORY STATUS:  🞏 Ambulatory 🞏 Nonambulatory

IMMUNIZATIONS GIVEN:  🞏 Yes 🞏 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.

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