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.