

MANITOWOC COUNTY FOSTER CARE PROGRAM
HEALTH REPORTS FOR FOSTER CHILD

Foster Child's name _____

Foster Child's address _____

Date examined _____ Date of TB Test _____ Results: Positive Negative (circle one)

Date of last Tetanus Shot _____

A. History (Circle where applicable)

- | | |
|------------------------|------------------------------|
| 1. Endocrine disorders | 6. Hepatitis A, B, C |
| 2. Diabetes | 7. Cancer |
| 3. Venereal diseases | 8. Operations (specify) |
| 4. Hypertension | 9. Other illnesses (specify) |
| 5. Mental illnesses | |

B. Physical Examination of Foster Child

1. General Health (Check appropriate spaces)

	Good	Poor
A. Nose and Throat	_____	_____
B. Heart	_____	_____
C. Lungs	_____	_____
D. Skin	_____	_____
E. Blood Pressure	_____	_____

2. General Vitality Level High____ Limited____

3. Prognosis for continued health (specify)

Please take the time, on the back of this form, to explain any health concerns you may have.

Physician's Signature _____

Address _____

Return to: Manitowoc County Human Services Department
Attention: Karen Zahn, Foster Care Administrator
P.O. Box 1177
Manitowoc, WI 54221-1177
(920) 683-4095