foundations
health & wholeness

Medical Exam

(to be completed **yearly**)

Foster Child: ______________________________ DOB: ____________

Date of Exam: ____________________________

A. Height:

Percentile: ______________

B. Weight:

Percentile: ______________

C. BMI:

Percentile: _______________

D. Vaccines Given (attach separate page if needed):

____

E. Medical Tests Performed:

____

____

F. Medications added, changed, or removed:

____

G. Recommendations/Concerns:

____

____

____________________________________ ______________________________
Provider Name Phone

____
Address City Zip

____
Provider Signature