



Annual Physical Exam

Child's Name _____ Date of Birth _____

Date of Exam _____

Name of Care Provider _____

Address of Care Provider _____

Phone Number of Care Provider _____

Age of Child _____ **Height** _____ **Weight** _____

Concerns/Diagnosis _____

Recommendations for follow-up care _____

Medications Prescribed _____

Signature of Care Provider _____ Date _____

Please return complete and return to the Foster Family
If you have your own office forms, please attach them to Hope & Home's form when submitting

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