MCCSB – 063, .01 / .02 / .03
Rev: 8-29-05

# PHYSICAL EXAMINATION / HEALTHCHEK

MARION COUNTY CHILDREN SERVICES BOARD
1680 Marion-Waldo Road Marion, Ohio 43302

**(Attention Office Manager – Please fax this form to CSB upon completion.)**

**(CHECK ONE THAT APPLIES)**

**CHILD'S NAME:** ______________________ ☐ **Communicable Disease - 01**

**CHILD'S D.O.B.** ______________________ ☐ **Initial Physical Exam - 02**

**DATE OF EXAM:** ______________________ ☐ **Annual Physical Exam - 03**

## EXAMINATION

Height ______________

Weight ______________

Gait ______________

Chest ______________

Heart ______________

Lungs ______________

Abdomen ______________

Neck ______________

Face / Head ______________

Lead Results ______________

Nose ______________

Tonsils/Adenoids ______________

Neurological ______________

Speech ______________

Urinalysis ______________

Hemoglobin / Hematocrit ______________

Tuberculine Tine Test ______________

Nutrition ______________

Teeth ______________

Skin ______________

Posture ______________

Eyes ______________ ☐ **Optical Exam Needed**

Ears ______________

Hair ______________

Extremeties ______________

Back ______________

**Genetalia:** **(M)** Discharge ______________ Sores ______________ Burning on Urination ______________

**(F)** Vaginal Discharge ______________ Sores ______________ Last Menses ______________

Vision Screening ______________ Hearing Screening ______________

**Comments or Recommendations:**

______________________
**Signature of Physician (or Examiner)**

**Initial Custody Date** ______________ **Expected Date of Initial Exam** ______________ **Expected Date of Next Exam** ______________

**IF MEDICAID, PLEASE BILL HEALTHCHEK**

**Copies to: Child's Caseworker CSB Receptionist Foster Parent**