People Places

Fostering hope for children and families.

Our Mission is to foster resilience in children and families so they can thrive.

Annual Medical Evaluation

Please complete all the blank areas of this form on front and back.
If the information does not apply, please indicate this with "NA".

Date of Exam: _____

Name: _____ **Date of Birth:** _____ **Sex:** _____

Height:		**Weight**	
B/P:		**Temp. :**	
Pulse:		**Resp:**	
Vision(Distance)	**R 20/**	**L 20/**	**Not Tested (Please Check)** ☐
Hearing Screening Results	**Left Ear**	**Right Ear**	**Not Tested (Please Check)** ☐

Current Physical Condition: Circle **N**ormal or **A**bnormal *(please explain abnormalities below)*

Skin	N	A	Eyes	N	A	Ears	N	A	Nose/Sinus	N	A
Throat/Neck	N	A	Structural	N	A	Psych/Mental	N	A	Genitourinary	N	A
Chest/Thorax	N	A	Heart	N	A	Lungs	N	A	Abdomen	N	A
Extremities	N	A	Neurological	N	A	Nutritional Status	N	A			

Child Growth, Health, and Developmental History: ☐ Within Normal Limits ☐ Abnormal

Allergies (*food, drug, environmental*): _____**Yes** ____**No**

If yes please explain:_____

_____

Does the child have any Chronic conditions, accidents, operations, disabilities, or nutritional, dental, mental, or emotional problems include: _____**Yes** ____**No**

If yes please explain_____

_____

_____

Recommendations/Referrals (including permitted or restricted activities):

_____

_____

Tuberculosis Screening

If **YES** to **ANY** questions, the patient must undergo skin test or chest x-ray.

Please consider the following questions to assess the patient's risk:	**Y**	**N**
1. Does the patient have signs/symptoms of active TB disease?	❑	❑
2. Is the patient a member of a high-risk group?	❑	❑
3. Has the patient ever lived with or been in close contact with anyone who had TB disease?	❑	❑
4. Has the patient ever had a positive HIV test?	❑	❑
5. Has the patient ever had a positive TB test?	❑	❑
6. Has the patient ever used illegal intravenous drugs?	❑	❑
7. Has the patient ever been incarcerated?		
8. Has the patient ever been homeless?	❑	❑
9. Does the patient currently have any of the following: cough, fever, night sweats, or weight loss that is unexplained and has lasted at least three weeks?	❑	❑
10. Was the patient born in, a resident of, or visitor to (spending six weeks or more) countries where TB is endemic?		

Based on the available information, the individual can be considered free of tuberculosis in a communicable form. (Circle) Yes No

PLEASE USE THIS SPACE TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY (based on assessment of criteria outlined above)

A. Tuberculin Skin Test (to be read in 48 to 72 hours)

Date given: ____ / ____ / ____ Date read: ____ / ____ / ____ Result: _____ mm

(Record actual mm of induration, transverse diameter; if no induration, write "0")

INTERPRETATION: ❑ **NEGATIVE** ❑ **POSITIVE**

B.Chest X-ray (required if PPD is positive or patient is at risk for disease)

Date of X-ray: ____ / ____ / ____ **RESULT:** ❑ **NORMAL** ❑ **ABNORMAL**

Please attach a copy of immunization record

Health Care Provider Information *(signature, title, and complete the information below required for validation)*

Provider's Signature: _____ **Date:** _____

Provider's Name and Title: (printed) _____

Practice Name: _____

Address: _____

Phone Number/Fax Number: _____

Return This Form To:

□ Staunton
1215 N. Augusta Street
Staunton VA 24401
Phone: (540) 885-8841
Fax: (540) 886-6379

□ Charlottesville
1002 E. Jefferson Street
Charlottesville VA 22902
Phone: (434) 979-0335
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3201 Peoples Drive
Harrisonburg VA 22801
Phone: (540) 437-1857
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