PHYSICIANS REPORT ON CHILD

Name of Child:_____ Date Examined_____

Date of Birth_____ Height_____ Weight_____

GENERAL HEALTH AND PHYSICAL CONDITION: (Check if normal. Describe below if abnormal.)

Eyes____ Mouth_____ Abdomen _____ Neurological_____

Ears____ Circulatory_____ Extremities_____ Lungs_____

Nose____ Heart_____ Genito-Urinary____ Throat_____

Gynecological_____ Other_____

Describe abnormalities noted above

_____

_____

_____

Other Significant physical findings

_____

_____

Recommendations for any above findings

_____

_____

History of previous illnesses and/or surgery_____

Your evaluation of physical and mental development

_____
_____

How long has this child been under your
care?_____
_____

Dated this_____day of _____, 20____

_____

Physician's Signature

_____

Physician's Name (print or type)

_____

Physician's Address (print or type)

I certify that this is a true document and my child's physician in my presence has signed this document.

_____

Adoptive Fathers Signature

OR

_____

Adoptive Mothers Signature

Ed: 12/3/13