

COUNTY OF LOS ANGELES • DEPARTMENT OF CHILDREN AND FAMILY SERVICES
MEDICAL EXAMINATION FORM - INSTRUCTIONS

DCFS 561(a)

Please refer to the MEDICAL RECORD PROCEDURES FOR FOSTER CAREGIVERS on the reverse side of this form.

(To be completed by CSW/Caregiver. Please print legibly.)

Infants (0-2 years) or 'High Risk' children must be medically examined within three (3) days of initial placement. 'High Risk,' means one or more of the following conditions exists: a past or present significant medical problem or chronic illness; possible contagious disease; on medication; and/or a social problem (e.g., language barrier) which might conceal an unmet medical need.

Child must have medical exam within thirty (30) days of initial placement.

Child needs annual/age-appropriate medical exam by _____.

CHILD's NAME: _____ DOB: _____ CASE #: _____ DATE PLACED: _____

CAREGIVER: _____ (Phone) _____ (FFA) _____ (Phone) _____

CSW: _____ (File #) _____ (Phone) _____ (Fax) _____

Medical data entered into CWS/CMS by: (Name) _____ (Date) _____

MEDICAL EXAMINATION FORM (To be completed by Doctor)

PHYSICAL EXAMINATION

Doctor is a CHDP provider? Yes No Was child tested for lead poisoning? Yes No

Date of Physical Examination: _____ Name of Doctor: _____

- Initial CHDP/CHDP-equivalent examination.
- Annual/age-appropriate CHDP/CHDP-equivalent examination.
- Other/Follow-up visit.
- Doctor's own exam form or PM 160 attached. If not attached, complete below.
- Entered into Health and Education Passport.

Physical Exam results: Age: _____ (Yrs.) _____ (Mos.) _____ (Wks.) Height: _____ % _____ Weight: _____ % _____
(May be continued on additional pages if necessary. If so, provider must date and sign second page.)

(Treatment given; Medications Prescribed. Please attach copies of supporting documentation; test results, etc.)

If follow-up care indicated, specify: _____

Immunizations given: _____
(If appropriate, complete Immunization Record)

Signature of Health Care Provider: _____ (Date) _____
(Doctor, Nurse Practitioner, Physician's Assistant)

Address: _____ Phone: _____

(Signature Stamp Required)