

### CHILD'S MEDICAL EXAMINATION FORM

**1. IDENTIFYING INFORMATION**  
*(To be completed by Case Manager)*

Child's Name \_\_\_\_\_ NJS ID # \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex ( ) Male ( ) Female  
Address \_\_\_\_\_ Date of Last Examination \_\_\_\_/\_\_\_\_/\_\_\_\_

- |   |                                     |  |
|---|-------------------------------------|--|
| <p>1. Significant Family Health History</p> | <p>2. Significant Birth History</p> | <p>3. Developmental History<br/>( ) Advanced ( ) Delayed ( ) Average<br/>Comments:</p> |
|---|-------------------------------------|--|
4. Significant Illnesses, Operations, Allergies. Use of Therapeutic and Non-Therapeutic Drugs *(include dates)*. Religious or other prohibitions against medications.

5. Significant Injuries *(include dates)*
- | 7. Tests <i>(if known)</i> | Date | Positive | Negative |
|----------------------------|------|----------|----------|
| TB                         |      |          |          |
| PKU                        |      |          |          |
| Lead Level                 |      |          |          |
| Sickle Cell                |      |          |          |
| STD                        |      |          |          |
| Hemoglobin                 |      |          |          |
| Urinalysis                 |      |          |          |
| Rape Kit                   |      |          |          |
| Other                      |      |          |          |

6. Immunizations	Dates
DTP (Diphtheria-Tetanus-Pertussis)	
OPV (Oral Polio Vaccine)	
MMR (Measles-Mumps-Rubella)	
DTP (Booster No. 1)	
OPV (Booster No. 1)	
DTP (Booster No. 2)	
OPV (Booster No. 2)	
DT (Diphtheria-Tetanus) Booster	
Other	

8. Is this to be an EPSDT examination? ( ) Yes ( ) No If yes, physician must complete MC-19 form.

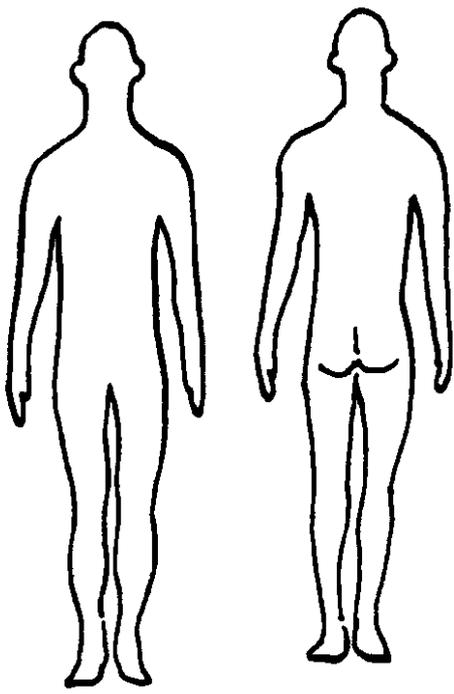
**II. PHYSICAL EXAMINATION** *(Please complete each of the following items):*  
*(To be completed by Physician)*

Pulse \_\_\_\_\_ Temperature \_\_\_\_\_ Blood Pressure (from 3 years) \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Respiration \_\_\_\_\_ Head Circumference \_\_\_\_\_

SYSTEM	OK	PROBLEMS FOUND	If problems found, note action taken; e.g. referred, treatment given, etc.
Eyes			
Ears			
Teeth, Mouth and Throat			
Cardiovascular			
Digestive			
Endocrine			
Genitalia			
Hemic-Lymph			
Integumental			
Musculo-Skeletal			
Nervous			
Respiratory			
Urinary			

III. SUSPECTED ABUSE REPORTING (completed by physician)

Child's Name \_\_\_\_\_



1. **Markings On Child** – Using the drawings indicate with numbers the location of lesions or marks that you observed. Further describe each numbered mark in the corresponding blanks below.

#1 Size, Color, Nature \_\_\_\_\_

\_\_\_\_\_

Age of Mark \_\_\_\_\_

Cause: ( ) Accidental ( ) Other than Accidental ( ) Physiological

Instrument used? \_\_\_\_\_

#2 Size, Color, Nature \_\_\_\_\_

\_\_\_\_\_

Age of Mark \_\_\_\_\_

Cause: ( ) Accidental ( ) Other than Accidental ( ) Physiological

Instrument Used? \_\_\_\_\_

#3 Size, Color, Nature \_\_\_\_\_

\_\_\_\_\_

Age of Mark \_\_\_\_\_

Cause: ( ) Accidental ( ) Other than Accidental ( ) Physiological

Instrument used? \_\_\_\_\_

2. Other Evidence of Injury

3. Explanation of Marks / Injuries  
Parent / Caretaker:

Child:

4. Physician's Comments: Please give your overall findings and conclusions in regard to the suspected abuse of this child.

IV. SIGN-OFF (Please type or print)

\_\_\_\_\_  
Name of Examining Physician

\_\_\_\_\_  
Telephone (Include area code)

Address \_\_\_\_\_  
Street City State Zip Code

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of Supervising Nurse (when appropriate)

\_\_\_\_\_  
Place Where Examination Performed