

Family & Children Services

A Source of Hope

CHILD'S ILLNESS REPORT

Patient Name: _____

Date of exam: _____

1. Physical examination

Weight _____	Height _____	Head circumference _____
Temp _____	Heart _____	Chest circumference _____
Eyes, nose, mouth _____	Lungs _____	Abdomen _____
Genitals _____	Extremities _____	Reflexes _____
Skin _____		

2. Condition: Normal _____ Abnormal _____

Diagnosis:

Recommendations:

(treatment, prescription, dietary changes, care)

3. Immunizations given on this date:

4. Comments on general appearance, motor or intellectual development:

Signature of attending physician

Date