# BERKS COUNTY CHILDREN & YOUTH SERVICES
## PHYSICAL EXAMINATION
Initial and Well Child Check Ups

☐ Initial Medical ☐ 6 week ☐ 12 week ☐ 6 month
☐ 9 month ☐ 12 month ☐ 15 month ☐ 18 month
☐ 24 month ☐ Annual

Child's Name ____________________________________ Date of Birth: ___________________________

Date of Exam: _________________________________

Height __________________ Weight ____________________

Treatment Received and Recommendations: ______________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Immunizations: (If child received Immunizations please attach a copy of the updated immunization record): _________
______________________________________________________________________________________________

Treatment Recommendations: ____________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Medication Prescribed: ________________________________________________________________________

Special Care:_______________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Medical Test Required: ________________________________________________________________________
______________________________________________________________________________________________

Follow Up Appointments: ______________________________________________________________________

Name of Physician: _____________________________________________________________________

Signature of Person Completing the Form: _____________________________________________________

Print/Type
Physician Name: ____________________________________________
Address: ___________________________________________________
Phone Number: ______________________________________________