Agape for Youth, Inc.
Form 17e

Documentation of Medical/Dental Care

Child's Name: ____ D.O.B. ______________
Date of Exam: ______________________
Provider: ____
Address: ____
If performing a complete physical, please note the following:

Height: ________ Weight: ________ Blood Pressure: ________

Abdomen: _________________
Ears: ______________________
Eyes: ______________________
Heart: _____________________
Hernia: ____________________
Lungs: ____________________
Lymph Glands: ______________

Neurological: _____________________
Skin: ___________________________
Throat: __________________________
Thyroid: _________________________
Tumors: _________________________
Extremities & Reflexes: _____________

Findings/Treatment Recommendations:

____
____
____
____
____
____
____
____

____ ________________________
Provider's Signature Date

Please indicate type of exam completed. If the vision/hearing screen was completed during the physical exam, please check the appropriate box.

____ Physical Exam
____ Vision Screening
____ Hearing Screening

____ Optical Exam
____ Dental Exam

Developed: 1/05/05
Revised: