



DEPARTMENT OF ADOPTION AND FAMILY SUPPORTIVE SERVICES

MARGARET LARAVIERE

DIRECTOR

118 N. CLARK ST, SUITE 806 • CHICAGO, ILLINOIS 60602 • P: (312) 603-0550 • F: (312) 603-9909

TONI PRECKWINKLE

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PEDIATRICIAN'S REPORT

Child's Name: _____

Sex: Male/Female: _____ **Date of Birth:** _____

PHYSICAL CHARACTERISTICS:

Weight: _____

Height: _____

List any observable physical abnormalities: _____

Health History:

Immunizations and Date

Given: _____

Diphtheria/Pertussis/Tetanus: _____

Measles/Mumps/Rubella: _____

Polio: _____

Whooping Cough: _____

TB: _____

Illnesses & Treatment to date: _____

Is the overall development of this child satisfactory? _____

If no, why? _____

Do you have any concerns about the parents' ability to care for the child(ren)?

Print Physician's Name

Date

Physician's signature required

Address/phone Stamp