COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE

GENERAL PHYSICAL EXAMINATION FOR A FOSTER CARE AND/OR ADOPTIVE APPLICANT

TO EXAMINING PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER

The applicant's permission for releasing information is given below. In evaluating the applicant, this agency must be guided by your medical findings, as reported on this form. It is necessary to determine that the applicant has no communicable diseases, has a reasonable life expectancy, and is capable both physically and emotionally, of carrying out the responsibilities of fostering or adopting.

Please mail the completed form(s) in an envelope marked "CONFIDENTIAL" to:

_______________________________________County Department of Human/Social Services or Child Placement Agency (CPA)

Attention: ____

Address: ____

____

PLEASE TYPE OR PRINT:

Physician's Name: ____

Address: ____

City: ______________________________State: ______________ Zip Code: _____________

Telephone Number: ____

I, ____ _________________________________
(Signature of Applicant) *(Address)*

________________________________ hereby give my permission for release to the
(Telephone Number)

____________________ County Department of Human/Social Services or Child Placement Agency (CPA), complete information about the condition of my physical, emotional, and mental health

PATIENT'S NAME: ______________________________ BIRTHDATE__________________

History of Major Illnesses and Hospitalizations: ______________________________________

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COLORADO
Office of Children, Youth & Families
Division of Child Welfare

PHYSICAL EXAMINATION: (must be within one year prior to certification or within 30 calendar days after certification)

Date of Examination: ____

Prescribed medication: ____

Is patient receiving treatment for a chronic illness? ________________Yes ______________No

What is the diagnosis? ____

What is the prognosis? ____

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Is the patient current with the Influenza vaccine? Yes _____ No ______ N/A______

Is the patient current with Tdap? Yes _____ No ______ N/A______

Date of current vaccinations Influenza _________ Tdap_________

If no, is/are the vaccine medically contraindicated for this adult?

Yes _____ No ______ N/A______

General Condition of Health: ____

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Identify any emotional, mental health, substance abuse, or physical conditions of the patient that could adversely affect children/youth in the home. Yes _____ No ______ N/A______

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How long have you known the patient? ____

If you know the patient well enough, please give your impression of patient’s emotional capacity to be a foster or adoptive parent.

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Unless a shorter timeframe is indicated below, the next health evaluation will be required in two (2) years. Date: _______________________

If less than 2 years, indicate the Date or Number of Months: _____________________

Examining Physician, Physician Assistant, or Nurse Practitioner:

____
Signature

____
Date of Report