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

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: _____

_____

_____

_____

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? _____

_____

_____

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: _____

_____

_____

_____

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_____

_____

_____

_____

_____

_____

_____

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.

_____

_____

_____

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