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

COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE

GENERAL PHYSICAL EXAMINATION FORM FOR CHILDREN, YOUTH, AND OTHER ADULTS IN THE FOSTER AND/OR ADOPTIVE HOME

TO EXAMINING PHYSICIAN, PHYSICIAN ASSISTANT, or NURSE PRACTITIONER:

The permission for releasing information about Children, Youth, and Other Adults in the Foster/Adoptive Home is given below. Please mail the completed form(s) in an envelope marked "CONFIDENTIAL" to: _____ County Department of Human/Social Services or the Child Placement Agency (CPA) identified.

Attention:_____

Address: _____

_____

PLEASE TYPE OR PRINT:

Physician's Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Telephone Number: _____

I, _____ _____
(Signature of Parent/Guardian of Child(ren)/Youth) *(Address)*

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

_____ County Department of Human/Social Services or Child Placement Agency, complete information about the condition of my child's (for Parent/Guardian) physical, emotional, and mental health.

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

CHILD/YOUTH 1

Name of Child/Youth: _____ Birth Date: _____

Date of Examination: _____

General Condition of Health: _____

_____

_____

_____

Prescribed medication: _____ _____

Is the child/youth receiving treatment for a chronic illness? _____Yes _____No

What is the diagnosis? _____

What is the prognosis?_____

Is this child/youth current with all vaccinations recommended by the CDC* and ACIP**

Yes___ No___ NA _____

If no, indicate which vaccination(s) is/are not current:

_____ _____ _____

Are there 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_____

_____

_____

_____

Unless a shorter time frame 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

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CHILD/YOUTH 2

Name of Child/Youth _____ Birth Date: _____

Date of Examination: _____

General Condition of Health: _____

_____

_____

_____

Prescribed medication: _____

Is the child/youth receiving treatment for a chronic illness? _____Yes _____No

What is the diagnosis? _____

What is the prognosis? _____

Is there 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_____

_____

_____

_____

Is this child/youth current with all vaccinations recommended by the CDC* and ACIP**

Yes___ No___ NA _____

If no, indicate which vaccination(s) is/are not current:

_____ _____ _____

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

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ADULT 1

Adult's Name: _____ Birth Date: _____

Date of Examination: _____

Prescribed medication: _____

Is the 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? _____

List any physical, emotional, or mental health conditions of the patient that could adversely affect children/youth who are in care in the home.

_____

_____

_____

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

****

ADULT 2

Adult's Name: _____ Birth Date: _____

Date of Examination: _____

Prescribed medication: _____

Is the 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? _____

List any physical, emotional, or mental health conditions of the patient that could adversely affect children/youth who are in care in the home.

_____

_____

_____

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