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: ____

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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: ____

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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______

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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:

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Signature

____
Date of Report

CHILD/YOUTH 2

Name of Child/Youth ________________________________ Birth Date: __________________

Date of Examination: _____________________

General Condition of Health: ____

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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______

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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:

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Signature

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Date of Report

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? ____

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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______

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.

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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:

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Signature

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Date of Report

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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? ____

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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______

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.

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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:

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Signature

____

Date of Report