COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

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

TO EXAMINING PHYSICIAN:

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.

Physician's office, please mail completed forms in an envelope marked "CONFIDENTIAL" to:

Project 1.27, 14000 E. Jewell Ave., Aurora, CO 80012

PLEASE TYPE OR PRINT:

Physician's Name: _____ Phone number: _____

Address: _____ City, State, Zip: _____

RELEASE OF INFORMATION:

Applicant's Name: _____Phone number: _____

Address: _____ City, State, Zip: _____

D.O.B. _____

I, _____, hereby give my permission for release to the _____ County Department of Human Services/CPA complete information about the condition of my physical, emotional, and mental health.

Signature _____ Date _____ CWS-12-A

ADULT

Adult's Name: _____ D.O.B. _____
Date of this Examination: _____
Prescribed medications _____
Is patient receiving treatment for a chronic illness? _____ Yes _____ No
What is the diagnosis? _____
What is the prognosis? _____
_____
_____
General Condition of Health: _____
_____
_____
_____

How long have you known the patient? _____

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

_____
_____

Unless a shorter timeframe is indicated here, the next health evaluation will be required in two years. _____
Alternate Date

_____ _____ _____
Examining Physician (Please Print) Examining Physician Signature Date of Report