COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

GENERAL PHYSICAL EXAMINATION FORM FOR CHILDREN 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

CHILDREN

Child's Name: ______________________________ D.O.B. ____________________________

Date of this Examination: _________________________

General Condition of Health: ____

____

Prescribed medications ____

Is patient receiving treatment for a chronic illness? _____ Yes _____ No

What is the diagnosis? ____

What is the prognosis? ____

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

____

____

Date of last Flu Vaccine* __________________ Date of last Pertussis Vaccine* __________________

*For foster/adoptive families caring for infants and/or children/youth with special medical needs: All household members must have a current pertussis vaccine and an annual flu vaccine, unless immunization is contrary to the patient's health as documented by a licensed health care professional.

Unless a shorter timeframe is indicated here, the next health evaluation will be required in one year

____

Alternate Date

__________________________________	__________________________________	_________________
Examining Physician (Please Print)	Examining Physician Signature	Date of Report

Child's Name: ______________________________ D.O.B. ____________________________

Date of this Examination: _________________________

General Condition of Health: ____

____

Prescribed medications ____

Is patient receiving treatment for a chronic illness? _____ Yes _____ No

What is the diagnosis? ____

What is the prognosis? ____

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

____

____

Date of last Flu Vaccine* __________________ Date of last Pertussis Vaccine* __________________

*For foster/adoptive families caring for infants and/or children/youth with special medical needs: All household members must have a current pertussis vaccine and an annual flu vaccine, unless immunization is contrary to the patient's health as documented by a licensed health care professional.

Unless a shorter timeframe is indicated here, the next health evaluation will be required in one year

____

Alternate Date

__________________________________	__________________________________	_________________
Examining Physician (Please Print)	Examining Physician Signature	Date of Report

Child's Name: ______________________________ D.O.B. ____________________________

Date of this Examination: _________________________

General Condition of Health: ____

____

Prescribed medications ____

Is patient receiving treatment for a chronic illness? _____ Yes _____ No

What is the diagnosis? ____

What is the prognosis? ____

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

____

____

Date of last Flu Vaccine* __________________ Date of last Pertussis Vaccine* __________________

*For foster/adoptive families caring for infants and/or children/youth with special medical needs: All household members must have a current pertussis vaccine and an annual flu vaccine, unless immunization is contrary to the patient's health as documented by a licensed health care professional.

Unless a shorter timeframe is indicated here, the next health evaluation will be required in one year

____

Alternate Date

_________________________________ _________________________________ __________________

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

Child's Name: ______________________________ D.O.B. ____________________________

Date of this Examination: _________________________

General Condition of Health: ____

____

Prescribed medications ____

Is patient receiving treatment for a chronic illness? _____ Yes _____ No

What is the diagnosis? ____

What is the prognosis? ____

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

____

____

Date of last Flu Vaccine* __________________ Date of last Pertussis Vaccine* __________________

*For foster/adoptive families caring for infants and/or children/youth with special medical needs: All household members must have a current pertussis vaccine and an annual flu vaccine, unless immunization is contrary to the patient's health as documented by a licensed health care professional.

Unless a shorter timeframe is indicated here, the next health evaluation will be required in one year

____

Alternate Date

__________________________________ __________________________________ _________________

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