

**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: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone number: \_\_\_\_\_

**RELEASE OF INFORMATION:**

Applicant's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone number: \_\_\_\_\_ 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 \_\_\_\_\_

**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