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: _____

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 _____

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

CHILDREN

Child's Name: _____ D.O.B. _____

Date of this Examination: _____

General Condition of Health: _____

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Prescribed medications _____

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

What is the diagnosis? _____

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

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

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Alternate Date

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