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:

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. It is necessary to determine that the applicant has no communicable diseases, has a reasonable life expectancy, and is capable both physically and emotionally, of carrying out the responsibilities of parenthood.

Please mail the completed form(s) in an envelope marked "CONFIDENTIAL" to:

Larimer County Department of Human Services

Attention: **Foster Care Program at Larimer County Department of Human Services**

Address: **1501 Blue Spruce Fort Collins, CO 80524** Email: fostercare@larimer.org

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)
(Telephone Number)

Larimer County Department of Human/Social Services, complete information about the condition of my 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:

_____

_____

_____

_____

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_____

_____

_____

_____

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:

_____
Signature

_____
Date of Report (required)

CHILD/YOUTH 2

Name of Child/Youth _____ Birth Date: _____

Date of Examination: _____

General Condition of Health: _____

_____

_____

_____

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_____

_____

_____

_____

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:

_____

Signature

_____

Date of Report (required)

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? _____

_____

_____

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: _____

_____

_____

_____

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.

_____

_____

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:

_____ _____

Signature Date of Report (required)

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? _____

_____

_____

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: _____

_____

_____

_____

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.

_____

_____

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:

_____ _____

Signature Date of Report (required)