COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

GENERAL PHYSICAL EXAMINATION FOR A FOSTER CARE AND/OR ADOPTIVE APPLICANT

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:

_______________________________________County Department of Human/Social Services

Attention: ____

Address: ____

____

PLEASE TYPE OR PRINT:

Physician's Name: ____

Address: ____

City: ______________________________State: _____________ Zip Code: ____________

Telephone Number: ____

I, ____ _________________________________
(Signature of Applicant) *(Address)*

________________________________ hereby give my permission for release to the
(Telephone Number)

____________________ County Department of Human/Social Services, complete information about the condition of my physical, emotional, and mental health.

PATIENT'S NAME: ______________________________ BIRTHDATE__________________

History of Major Illnesses and Hospitalizations: ______________________________________

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PHYSICAL EXAMINATION: (must be within one year prior to certification or within 30 calendar days after certification)

Date of this Examination: ____

What medications are prescribed? ____

Is patient receiving treatment for a chronic illness? ____________Yes ___________No

What is the diagnosis? ____

What is the prognosis?____

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General Condition of Health: ____

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Describe any factors for this patient that should be considered if out-of home care is provided to children (mental health, substance abuse, illness, physical disability, etc.):

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How long have you known the patient? ____________________________________

If you know the patient well enough, please give your impression of patient's emotional capacity to be a foster or adoptive parent.

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

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Alternate Date

_________________________ _________________________
Date of Report Signature of Examining Physician