

**COLORADO DEPARTMENT OF HUMAN SERVICES  
DIVISION OF CHILD WELFARE SERVICES**

**GENERAL PHYSICAL EXAMINATION FORM FOR CHILDREN AND OTHER ADULTS IN THE  
FOSTER AND/OR ADOPTIVE HOME**

TO EXAMINING PHYSICIAN:

The permission for releasing information about Children and Other Adults in the Foster/Adoptive Home is given below. 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 Parent/Guardian of Child(ren) or the Other Adult) \_\_\_\_\_ (Address)

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

\_\_\_\_\_ County Department of Human/Social Services, complete information about the condition of my child(ren's) (for Parent/Guardian) or my (for Other Adult's) physical, emotional, and mental health.

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

**CHILDREN**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date of this Examination: \_\_\_\_\_

General Condition of Health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescribed medication: \_\_\_\_\_

Is the child 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.

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Alternate Date

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date of this Examination: \_\_\_\_\_

General Condition of Health: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescribed medications: \_\_\_\_\_

Is the child receiving treatment for a chronic illness? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is the diagnosis? \_\_\_\_\_

What is the prognosis? \_\_\_\_\_

List any emotional, mental health, or physical 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

\_\_\_\_\_  
Date of Report

\_\_\_\_\_  
Signature of Examining Physician

**ADULT**

Adult's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date of this Examination: \_\_\_\_\_

Prescribed medications \_\_\_\_\_

Is the 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 who are in care in the home.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Alternate Date

\_\_\_\_\_  
Date of Report

\_\_\_\_\_  
Signature of Examining Physician