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