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: ____

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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.

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____

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: ____

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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.

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____

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?____

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General Condition of Health: ____

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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.

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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