

**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: _____

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? _____

General Condition of Health: _____

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.):

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.

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