COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

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

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.

Physician's office, please mail completed forms in an envelope marked **"CONFIDENTIAL"** to:

Project 1.27
2220 S Chambers Road
Aurora CO 80014

PLEASE TYPE OR PRINT:

Physician's Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone number: ______________________________

RELEASE OF INFORMATION:

Applicant's Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone number: ____________________ D.O.B. ________________

I, ______________________________, hereby give
(Signature of applicant)
my permission for release to the _______________ County Department of Human Services/CPA complete information about the condition of my physical, emotional, and mental health.

ADULT

Adult's Name: ____________________________ Birth Date: ________________________

Date of this Examination: ____

Prescribed medications: ____

Is the child receiving treatment for a chronic illness? ____________Yes ___________No

What is the diagnosis? ____

What is the prognosis? ____

____

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 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

CWS-12-A