COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE

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

TO EXAMINING PHYSICIAN:

The permission for releasing information about Children, Youth, 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:___Project 1.27_____

Address: ___2220 S. Chambers Road, Aurora, CO 80013_____

_____

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) (for Parent/Guardian) or my (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/YOUTH

Child's Name: _____ Birth Date: _____

Date of Examination: _____

General Condition of Health: _____

_____

_____

_____

Prescribed medication: _____ _____

Is the child/youth 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/youth in the home.

_____

_____

Unless a shorter timeframe is indicated below, the next health evaluation will be required in one (1) year.

_____
Alternate Date (if less than one year)

Child's Name: _____ Birth Date: _____

Date of Examination: _____

General Condition of Health: _____

_____

_____

_____

Prescribed medication: _____

Is the child/youth 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 effect children/youth in the home.

_____

_____

Unless a shorter timeframe is indicated below, the next health evaluation will be required in one (1) year.

_____
Alternate Date (if less than one year)

_____ _____

Date of Report

Signature of Examining Physician or Other Qualified Health Professional

ADULT

Adult's Name: _____ Birth Date: _____

Date of Examination: _____

Prescribed medication: _____

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 effect children/youth who are in care in the home.

_____

_____

_____

Unless a shorter timeframe is indicated below, the next health evaluation will be required in one (1) year.

_____
Alternate Date (if less than one year)

_____ _____
Date of Report Signature of Examining Physician or Other Qualified Health Professional