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

COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE

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: ____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 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 Examination: _____

Prescribed medication: _____

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 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

COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

GENERAL PHYSICAL EXAMINATION FORM FOR CHILDREN 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.

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.

_____
Alternative Date

_____ _____
Date of Report Signature of Examining Physician

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.

_____
Alternative Date

_____ _____
Date of Report Signature of Examining Physician

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.

_____
Alternative Date

_____ _____
Date of Report Signature of Examining Physician

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.

_____
Alternative Date

_____ _____
Date of Report Signature of Examining Physician

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: _____

_____

_____

_____

_____

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.

_____

_____

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**