COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

GENERAL PHYSICAL EXAM 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 of both physically and emotionally carrying out the responsibilities of parenthood.

Please **fax this form to "Licensing" at Hope & Home (719-575-0553)** or mail the completed form(s) in an envelope marked "CONFIDENTIAL" to:

HOPE & HOME
Attn: Licensing
4945 N. 30th St, Third Floor
Colorado Springs, CO 80919

PLEASE TYPE OR PRINT:

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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 my physical, emotional, and mental health.

PATIENT'S NAME: _____ BIRTH DATE:_____

Date of This Examination: _____

Prescribed Medications: _____

Is this patient receiving treatment for a chronic illness? Please Circle Yes No

What is the diagnosis? _____

What is the prognosis? _____

_____

_____

General Condition of Health: _____

_____

_____

How long have you known the patient? _____

History of Major Illnesses or Hospitalization: _____

_____

_____

_____

List any physical, emotional, or mental health conditions of the patient that could adversely affect children who are in care 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