COLORADO DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD WELFARE SERVICES

GENERAL PHYSICAL EXAM FOR CHILDREN AND OTHER ADULTS IN THE FOSTER AND/OR ADOPTIVE HOME

TO EXAMINING PHYSICIAN:
The applicant's permission for releasing information about Children and Other Adults in the Foster/Adoptive Home is given below.

Please fax to 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 Parent/Guardian of Child(ren) or of the Other Adult) *(Address)*
_____ hereby give my permission for release to the
(Telephone Number)
_____ County Department of Human/Social Services, complete information about my child(ren)'s (for Parent/Guardian) or my (for 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)

CHILD or ADULT'S NAME:

_____ Birth Date:_____

Date of this Examination: _____

General Condition of Health: _____

_____

Prescribed Medication: _____

Is this person receiving treatment for a chronic illness? Please Circle 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. **M.D. SIGNATURE:_____**Alternate Date_____

ADDITIONAL CHILD or ADULT's NAME:

_____ Birth Date:_____

Date of this Examination: _____

General Condition of Health: _____

_____

Prescribed Medication: _____

Is this person receiving treatment for a chronic illness? Please Circle 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. **M.D. signature**:_____

Alternate Date_____