Hope & Home Physical Exam Form for Foster Care & Adoption

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 finding, 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 fulfilling their role in the Foster/Adoptive home/environment.

Please return completed form to patient or email to licensing@hopeandhome.org.

Physical form for: ____

- ☐ Foster Parent
- ☐ Child
- ☐ Additional Adult in home
- ☐ Support person

Signature: ____

(Signature of patient/Legal Guardian of minor)

By signing above, I hereby give my permission for release to the Colorado County Departments of Human/Social Services to complete information about the condition of my physical, emotional, and mental health.

Physician's Name: ____

Address:____

City/State/Zip: ____ Phone: _________________

Patient's Name: ____

Birthdate: ____ / ____ / ____   Age at time of examination: ________

PHYSICAL EXAMINATION DATE: _______ /________ /________

This physical will expire in two years unless a shorter timeframe is listed here: __________________

- **General Condition of Health:** ____
- **Prescribed Medications:** ____
- **Is this patient current on their immunizations?**   YES   NO

  *Please attach a copy of the patient's immunization record

- **History of major illness or hospitalization:** ____

  ____

- **Is this patient receiving treatment for a chronic illness?**   YES   NO
  - What is the diagnosis? ____
  - What is the prognosis? ____

    ____

- **List any of the patient's emotional, mental health, or physical conditions that could adversely affect foster children in the home:** _____________________________________

  ____

- **How long have you known the patient?** ___________________

____   __________________

Signature of examining physician   **Date of Report**