HEALTH EVALUATION FORM

I give permission for you to release complete information about my family's physical and mental condition.

Signature:____ **Address:**_________________________________

Date: ___________________________________ **Phone:** __________________________________

Dear Doctor: The above named persons are applicants for a family care home license to care for unrelated children in their home. Your opinion as to each person's freedom from physical or mental illness which might be detrimental to the care of a child is a governing factor in their being approved for a license. Be assured this information will be used for licensing purposes only.

It is the intention of this agency to intercept or prevent any relationship connected with child care which might adversely affect a child's health and social development.

WOMAN'S HEALTH:

Name: ____ **Date you last saw patient:**_____________________

Is patient under treatment for a chronic illness? ☐ **Yes** ☐ **No If so, what is diagnosis?**

____

General condition of health:____

____

What medications are prescribed?____

Describe any emotional or physical factors of this patient which should be considered if care is given to unrelated children.

____

The next examination may be in ☐ **<u>two</u> years for the purpose of license renewal** ☐ **or as follows:** ____________

(Date to be seen)

MAN'S HEALTH:

Name: ____ **Date you last saw patient:**_____________________

Is patient under treatment for a chronic illness? ☐ **Yes** ☐ **No If so, what is diagnosis?**

____

General condition of health:____

____

What medications are prescribed?____

Describe any emotional or physical factors of this patient which should be considered if care is given to unrelated children.

____

The next examination may be in ☐ **<u>two</u> years for the purpose of license renewal** ☐ **or as follows:** ____________

(Date to be seen)

CHILDREN'S HEALTH:

Name: ____ Date you last saw patient:___________________
Is patient under treatment for a chronic illness? ☐ Yes ☐ No If so, what is diagnosis?

____

General condition of health:____

____

What medications are prescribed?____

Does this child have complete immunizations? ☐ Yes ☐ No

The next examination may be in ☐ two years for the purpose of license renewal ☐ or as follows: ____________
(Date to be seen)

OTHERS LIVING IN THE HOME:

Name: ____ Date you last saw patient:___________________
Is patient under treatment for a chronic illness? ☐ Yes ☐ No If so, what is diagnosis?

____

General condition of health:____

____

What medications are prescribed?____

Describe any emotional or physical factors of this patient which should be considered if care is given to unrelated children.

____

The next examination may be in ☐ two years for the purpose of license renewal ☐ or as follows: ____________
(Date to be seen)

Return completed health care evaluation to:

Bridges Child Placement Agency
1225 N. Main St, Ste 102
Pueblo, Co 81003-2827

____
Printed name of Physician

____
Address

____
City, State, Zip

____
Physician's signature

____
Date