HEALTH EVALUATION FORM

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

Patient/Parent/Guardian Signature: _____

Address: _____

Date: _____ **Phone:** _____

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

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)

_____
Printed name of Physician

_____
Address

_____
City, State, Zip

_____
Physician's signature

_____
Date

Return completed health care evaluation to:

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