



FOSTER HOME AND ADOPTIVE HOME HEALTH ASSESSMENT FORM

Patient Name: \_\_\_\_\_

Patient Birthdate: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Length of Time you have known Patient: \_\_\_\_\_

Licensed Health Care Name/Practice: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I, \_\_\_\_\_  
(Signature of Parent/Guardian of Child/Youth) (Address)

\_\_\_\_\_ hereby give my permission for release to the  
(Telephone Number)

\_\_\_\_\_ County Department of Human/Social Services or Child  
Placement Agency, complete information about the condition of my child's (for Parent/Guardian) physical,  
emotional, and mental health.

- General Condition of Health:**  **Good**- no concerns  **Fair**- minor concerns  
 **Poor**- several health concerns  **Chronic**-chronic health concerns

Please describe General Condition of Health if the rating above is marked Poor or Chronic:

Patient is receiving treatment for a Chronic Illness/Condition?  Yes - If "yes" please identify the condition below.  No

Chronic Illness/Condition	Diagnosis/Prognosis:



Is the Patient Prescribed Medication(s)?

Yes - If "yes" please list below.

No

Medication Prescribed:	Prescribed to Treat:

**ADULT SECTION RELATED TO VACCINATION(S):**

Patient is current with the following vaccinations: See Vaccinations Listed Below

Vaccination(s):	Current:			Date Expires:
Influenza	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Tdap	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
If "NO" is/are the vaccine(s) medically contraindicated for this Adults?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

**CHILD SECTION RELATED TO VACCINATIONS:**

Patient is current with ALL vaccinations recommended by the CDC\* and ACIP\*:  Yes  No  NA

If "No", indicate which vaccination(s) is/are Not current:	Date Due

§26-6-911(2)(g) C.R.S., requires the certifying agency to have a health assessment of foster care parents completed by a licensed healthcare professional with a written evaluation of the person's physical and mental ability to care for children/youth in foster care.

In your opinion, is there any identified emotional, mental health, substance abuse, or physical conditions of this patient that could adversely affect children/youth who would be directly in contact with this patient?

Yes - If "yes" please identify the concern(s) and any recommendations.

No



Concern(s):	Recommendation:

**What is your impression of the patient’s emotional capacity and their ability to provide support, care, and healthy interactions with children/youth in foster care?**

**Date of next Health Assessment:** \_\_\_\_\_

The time frame between health assessments cannot exceed two (2) years

*Examining Physician, Doctor of Osteopathic Medicine, Physician Assistant, or Nurse Practitioner*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date of Report

**The report should be sent as requested below:**

Please mail the completed form(s) in an envelope marked “CONFIDENTIAL” to:  
\_\_\_\_\_ County Department of Human/Social Services or the Child Placement Agency (CPA)  
identified.

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Encrypted and scanned to: \_\_\_\_\_

Faxed to: \_\_\_\_\_