Colorado Family Services, Inc.

HEALTH EVALUATION FORM-FAMILY CARE HOME

We (I) give permission to you to give the Colorado Family Services, Inc. complete information about our family's physical and mental condition.

Signature ______________________ Applicant's telephone number ______________________

Address ______________________

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Dear Doctor,

The above persons are applicants for a family foster 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 our agency to intercept or prevent any relationship connected with childcare, which might adversely affect a child's health and social development. For more than one child, please make additional copies of the appropriate form.

WOMAN'S HEALTH

Name ______________________ Date when you last saw patient ______________________

General condition of her health ______________________

Is patient under treatment for chronic illness? ❐ Yes ❐ No If yes, name illness ______________________

Is she on any medications ❐ Yes ❐ No If yes, what medications ______________________

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

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Is the patient free from communicable diseases? ❐ Yes ❐ No

❐ This patient needs to be seen every ❐ three years, ❐ two years, ❐ 1 year or ❐ other ______________________

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

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______________________ ______________________

Physicians Signature Date

______________________ ______________________

Physician's address Physician's phone

Physician's Comments: ______________________

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Colorado Family Services, Inc.
MAN'S HEALTH

Name ______________________ Date when you last saw patient ______________________

General condition of his health ______________________

Is patient under treatment for chronic illness? Yes ❒ No If yes, name illness ______________________

Is he on any medications ❒Yes ❒ No If yes, what medications ______________________

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

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Is the patient free from communicable diseases? ❒ Yes ❒ No If no, how often does the person need to be seen? ______________________

❒ This patient needs to be seen every ❒ three years, ❒two years, ❒ 1 year or ❒ other ______________________

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

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______________________ ______________________

Physicians Signature Date

______________________ ______________________

Physician's address Physician's phone

Physician's Comments: ______________________

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OTHERS LIVING IN THE HOME

Name ______________________ Date when you last saw patient ______________________

General condition of his/her health ______________________

Is patient under treatment for chronic illness? ❒Yes ❒ No If yes, name illness ______________________

Is (s)he on any medications ❒Yes ❒ No If yes, what medications ______________________

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

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Is the patient free from communicable diseases? ❒ Yes ❒ No

❒ This patient needs to be seen every ❒ three years, ❒two years, ❒ 1 year or ❒ other ______________________

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

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______________________ ______________________

Physicians Signature Date

______________________ ______________________

Physician's address Physician's phone

Physician's Comments: ______________________

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Colorado Family Services, Inc.

CHILDREN'S HEALTH

Name ______________________________ Date when you last saw patient ______________________

General condition of his/her health ____

Is patient under treatment for chronic illness? ❐ Yes ❐ No If yes, name illness ______________________

Is (s)he on any medications ❐ Yes ❐ No If yes, what medications ______________________

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

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Is the patient free from communicable diseases? ❐ Yes ❐ No

❐ This patient needs to be seen every ❐ three years, ❐ two years, ❐ 1 year or ❐ other ______________________

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

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______________________________________ ______________________

Physicians Signature Date

______________________________________ ______________________

Physician's address Physician's phone

Physician's Comments: ____

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CHILDREN'S HEALTH

Name ______________________________ Date when you last saw patient ______________________

General condition of his/her health ____

Is patient under treatment for chronic illness? ❐ Yes ❐ No If yes, name illness ______________________

Is (s)he on any medications ❐ Yes ❐ No If yes, what medications ______________________

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

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Is the patient free from communicable diseases? ❐ Yes ❐ No

❐ This patient needs to be seen every ❐ three years, ❐ two years, ❐ 1 year or ❐ other ______________________

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

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______________________________________ ______________________

Physicians Signature Date

______________________________________ ______________________

Physician's address Physician's phone

Physician's Comments: ____

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