2250 S. Oneida St. Suite 100, Denver, CO 80224, T (303) 433-1975 F (303)433-1980
1465 N Union Drive Suite 102 Colorado Springs, CO 80909 F: (719) 445-0841

Medical Examination form for NON-Foster Child in Home

FOSTER HOME: _____

To the examining physician,
This examination is for biological/adopted children/kin of the foster parents. PLEASE COMPLETE THE FORM, SIGN AND DATE, & AFFIX YOUR OFFICE STAMP NEXT TO YOUR SIGNATURE

Child's Name: _____Date: _____

GENERAL CONDITION OF HEALTH:

_____

_____

_____

COMMUNICABLE DISEASES:

_____

_____

List below any emotional, mental, or physical conditions of the child that could have an adverse affect on him/her in the home:

_____

_____

_____

- *Unless otherwise indicated here, the next health evaluation will be required in **TWO YEARS.***
- _____*Alternate date of the next health evaluation.*

PHYSICIANS SIGNATURE: _____ Date: _____

*****BE SURE TO AFFIX OFFICE STAMP*****