2250 S. Oneida St. Suite 200, Denver, CO 80224, T (303) 433-1975 F (303)433-1980
1465 N. Union Blvd. Suite 102 Colorado Springs, CO 80909, T (719) 694.8037 F (719) 445.0841

GENERAL PHYSICAL EXAMINATION
FOR PRIMARY FOSTER PARENT and/or ADOPTIVE APPLICANT 1

To the examining physician:
To become a licensed foster parent, it is necessary to determine that this applicant has no communicable diseases, has a reasonable life expectancy and is capable physically and emotionally of carrying out the responsibilities of parenthood. Maple Star will be guided by your medical findings as reported on this form.

- **PLEASE SIGN THE COMPLETED FORM, AFFIX YOUR OFFICE STAMP NEXT TO YOUR SIGNATURE AND RETURN TO THE APPLICANT**

APPLICANT/PATIENT Please type or print:

Physician's Name: ______________________________________Phone: __________________________
Address: _______________________________City: _______________________ State: ______________

I, ____, ____,
Printed name ***Signature***
__________________________, ____,
Phone ***Address***
Hereby give my permission to release to Maple Star Colorado complete information about my physical and mental condition.

PHYSICIAN Please Print

PATIENT'S NAME ____ BIRTHDATE _______________
HOW LONG HAVE YOU KNOWN THE PATIENT? ____
History of Major Illness and Hospitalizations:
Date: _________ *Illness:* ____
Date: _________ *Illness:* ____
Date: _________ *Illness:* ____

PHYSICAL EXAMINATION: *(Must be within year of application or yearly update)* **DATE of this exam:** ___________

Is patient under treatment for a chronic illness ___YES ___ NO
DIAGNOSIS: ____
IF A CHRONIC ILLNESS, WHAT IS TREATMENT PLAN? ____
____
List Medications prescribed: ____
____
PROGNOSIS: ____
COMMUNICABLE DISEASES: ____

DESCRIBE ANY FACTORS THAT SHOULD BE CONSIDERED IF PATIENT IS TO BE AROUND CHILDREN 24/7: ____
____

If you know the patient, please give your impression of his/her emotional qualifications to be a foster or adoptive parent: ____
____

GENERAL CONDITION OF HEALTH: ____
____
____

(Please use the back of this page for any additional information)

- *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

Rev 6-2018