



**GENERAL PHYSICAL EXAMINATION
FOR SECONDARY FOSTER PARENT and/or ADOPTIVE APPLICANT 2 or OTHER ADULT IN HOME**

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*****