Ariel Clinical Services

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540 Main Street, Suite 112
Delta, CO. 81416
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2145 Academy Circle
Colorado Springs CO 80909
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FOSTER FAMILY HEALTH EVALUATION FORM

This section is to be completed by the applicant(s). Evaluation is required for everyone residing in the home.

I authorize Dr. _____ to give the above named agency information about
(Physician's Name)

☐ **Myself** ☐ **My Family's physical and mental condition**_____
(Patient's Signature)

TO BE COMPLETED BY A PHYSICIAN:

The below mentioned person(s) is applying for a Foster Care Home license to care for unrelated or kinship care children in their home. Please indicate below your opinion as to whether any of the residents of this home suffer from any physical, mental or emotional illness or condition or any communicable disease, which could adversely affect children in their care. This information will be used for licensing purposes only.

1st Applicant Name: _____ Date of Birth _____

Doctor Signature: _____ Date: _____

Date you last saw this patient: _____

Is this patient under treatment for chronic illness? ☐ No ☐ Yes

If yes, what is the diagnosis: _____

What medications prescribed: _____

General Assessment of health: ☐ Good ☐ Fair ☐ Poor

List below any emotional, mental or physical conditions of the patient that could adversely affect non-related children in his/her care:

Date recommended for next health evaluation(s): _____

Unless otherwise indicated here, the next health evaluation will be required in two years.

2nd Applicant Name: _____ Date of Birth _____

Physician's Signature: _____ Date: _____

Date you last saw this patient: _____

Is this patient under treatment for chronic illness? ☐ No ☐ Yes

If yes, what is the diagnosis: _____

What medications prescribed: _____

General Assessment of health: ☐ Good ☐ Fair ☐ Poor

List below any emotional, mental or physical conditions of the patient that could adversely affect non-related children in his/her care:

_____

Date recommended for next health evaluation(s): _____

Unless otherwise indicated here, the next health evaluation will be required in two years.

Child's Name: _____ Date of Birth _____

Physician's Signature: _____ Date: _____

General Assessment of health: ☐ Good ☐ Fair ☐ Poor

List below any emotional, mental or physical conditions of the patient that could adversely affect non-related children in his/her care:

_____

_____

Date recommended for next health evaluation(s): _____

Unless otherwise indicated here, the next health evaluation will be required in two years.

Child's Name: _____ Date of Birth _____

Physician's Signature: _____ Date: _____

General Assessment of health: ☐ Good ☐ Fair ☐ Poor

List below any emotional, mental or physical conditions of the patient that could adversely affect non-related children in his/her care:

_____

_____

Date recommended for next health evaluation(s): _____

Unless otherwise indicated here, the next health evaluation will be required in two years.