Shadow Mountain Behavioral Health System

Therapeutic Foster Care

Foster Parent Medical Examination Report

Mr./Mrs./Ms. _____ has applied to this agency to board a child on a temporary basis. The 24-hour care of children requires that foster parents be able to meet responsibilities that are constant and demanding on both physical strength and emotional stability. We have their permission to consult you regarding their physical health: particularly to insure that the foster parent seems to receive adequate physical care and is free of communicable disease.
This information is strictly confidential.

Please complete the form below:

Name: _____ DOB: _____

Address: _____ County: _____

Height: _____ Weight: _____

GENERAL PHYSICAL EXAMINATION – REPORT OF FINDINGS: (To be completed by physician)

Check below if normal:

☐	Eyes	Any evidence of disease or disorders not correctable by glasses or contact lenses? _____
☐	Ears	Any evidence of deafness or other disease? _____
☐	Heart	Any evidence of enlargement, thrill, murmurs, or rhythm? _____
☐	Lungs	Any evidence of abnormality by history or physical? _____
☐	Abdomen	Any evidence of abnormality by history or physical? _____
☐	Nervous System	Any History of illness related to the nervous system? _____
☐	VDRL	Attach report, if indicated.
☐	Urine	Attach report, if indicated.
☐	EKG	Pulse Rate: _____
☐	Dyspnea	Blood Pressure: _____ Systolic
☐	Cyanosis	_____ Diastolic

MEDICAL HISTORY:

List any surgical procedure or communicable, hereditary, or debilitating diseases, including diabetes, psychoneurotic disorders, epilepsy or fainting spells. _____

_____

List current medications_____

_____

Does the patient have any condition that would impair his or her ability to provide daily care for children? If yes, explain:

_____

COMMENT OF PHYSICIAN: (Regarding patient's emotional, intellectual and physical health.)

_____

_____

For what period of time has this person been a patient? _____

_____ _____

Physician's Signature Date

_____ _____

Address Phone Number

Revised 2/05