UMFS

RP – 203b

MEDICAL REPORT ON CHILD

TO THE PHYSICIAN, PHYSICIAN'S DESIGNEE, OR LOCAL HEALTH DEPARTMENT OFFICIAL:
Please send the following information about my child's history and current health to the above named agency, with whom I am considering the fostering and/or adoption of a child. If the agency needs to consult with you for further understanding, I authorize you to discuss any pertinent details with the agency representative.

_____
(Signature of Applicant/Resource Parent)
_____ (Date)

Name: _____D.O.B._____
Address: _____Phone:_____
Worker's Name: _____

SIGNIFICANT MEDICAL HISTORY:
Physical
Major Illnesses (with dates)

_____
Major Operations (with dates)

_____
Disabilities

_____
Therapeutic Services (with dates)

_____
Hospitalizations (with dates)

CURRENT PHYSICAL EXAMINATION

Weight _____Height _____Blood Pressure _____

Impressions of general health: (Please check appropriate line)
_____ Patient is free from communicable and contagious disease.
_____ Patient is not free from communicable and contagious disease.

In so far as you are able to determine, is the patient in sufficiently good physical and mental health as to not jeopardize the health and safety of any foster child placed in his/her home?
Yes _____ No _____

If not, please give comments or recommendations: _____
_____
_____

Tuberculosis: Physician: Please indicate whether the household member is free from Tuberculosis in a communicable form and include the type(s) of test(s) used and the results. Please select the one most appropriate option.

☐ **TB Screening**: A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

☐ **TB Tine test**: Test results _____ Date Given _____ Date Read _____

☐ **Chest X-ray**: on (date) _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

☐ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease

☐ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

I have known the patient since: _____

Additional Comments: _____
_____
_____

I certify that I evaluated the physical condition of _____
on_____.
(Date)

_____
Name of Licensed Physician/Licensed Physician Designee's or Local Health Dept. Official ***(Please Print)***

_____
Signature of Licensed Physician/Licensed Physician Designee's or Local Health Dept. Official

Phone: _____

Address: _____
_____

Date: _____