RP – 203c

HEALTH STATEMENT
PERMANENT HOUSEHOLD MEMBER

TO THE PHYSICIAN, PHYSICIAN'S DESIGNEE, OR LOCAL HEALTH DEPARTMENT OFFICIAL: Please send the following information about my health to the above named agency. If the agency needs to consult with you for further understanding, I authorize you to discuss any pertinent details with the agency representative."

Name of Foster Family: _____

Address: _____

Name of Household Member/Care Provider: _____

1. **Please evaluate the current health status of this patient:**
   _____
   _____

2. **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.

3. **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.

4. Please indicate whether in your opinion the health of this household member or backup provider will not affect the care of foster children:

_____
Date of Evaluation

_____
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

UMFS
Unwavering champions for children and families.

RP – 203

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept./facility)

_____ 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.

_____ 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.

_____ 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 had a chest x-ray on _____ 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.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____
_____
_____