To: Medical Provider
From: UMFS Staff
Re: UMFS TFC MEDICAL FORM INSTRUCTIONS

Please complete each section of the Medical Form. NO WHITE OUT PLEASE

1. **Immunization** *(DOCUMENT ANY IMMUNIZATIONS GIVEN DURING VISIT AND INCLUDE ANY NEEDED IMMUNIZATIONS IN FOLLOW UP RECOMMENDATIONS OR STATE ALL UP TO DATE-NONE NEEDED AT THIS TIME)*

2. **Current Physical** (*PLEASE COMPLETE EACH SECTION, IF WITHIN NORMAL LIMITS PLEASE DOCUMENT THIS,* **NO AREA SHOULD BE LEFT BLANK***)*

   Height & Weight

   a. Growth and Development
   a. Vision
   b. Hearing
   c. Nutritional Status
   d. Free from communicable/infectious diseases including TB in a communicable form *(Please also complete the Report of TB Screening form)*
   e. Allergies
   f. Chronic Conditions and handicaps
   g. Lead Screening *(ATTACH RESULTS IF FURTHER TESTING IS WARRANTED)*
   h. HIV/STD Risk Assessment Screening *(SIMPLY SCREEN TO DECIDE IF FURTHER TESTING IS WARRANTED – IF WARRANTED, ATTACH RESULTS)*

3. **Current Medications**
   (INFORMATION WILL BE PROVIDED BY PARENT FOR COMPLETION OF THIS FORM)

4. **Need for any immediate medical or mental health care**
   (IF SO, EXPLAIN)

5. **Recommendations**
   (INCLUDE ANY FOLLOW UPS NEEDED)

SIGNATURE, TITLE, AND DATE OF EXAM MUST BE DOCUMENTED AT THE BOTTOM OF THE FORM

Thank you,
UMFS Staff

UMFS

Treatment Foster Care Medical Form

Complete within 72 hours of placement for COA screening & then at least 1x annually thereafter

Note: Also obtain 1) any physical completed 90 days prior to the placement date OR 2) the last physical exam plus any additional medical services received since that time when a youth has been in continuous foster care OR 3) the discharge summary if an infant is placed directly from the hospital

Child's Name:

1. **Current Physical Condition:** Height: Weight:

   a. Immunizations given in the past 13 months, or since the last evaluation:

   a. Growth and Development:

   b. Vision:

   c. Hearing:

   d. Nutritional Status:

   e. Evidence of freedom from infectious & communicable diseases including Tuberculosis in a communicable form:

   f. Allergies:

   g. Chronic Conditions and handicaps:

   h. Lead Screening: testing indicated? Yes_____ No_____. If yes please provide results.

   i. HIV/STD Screening: testing indicated? Yes_____ No_____. If yes please provide results.

1. **Current medications/dosage:**

2. **Need for any immediate medical or mental health care (if so, please explain):**

3. **Recommended Follow Up Care:**

This exam was completed by or under the direction of a licensed physician.

_____

Signature & Title of Examiner

_____

Date of Examination

This Form Last Revised 12/2013

UMFS

COVID-19 SCREENING

This screening form must be completed prior to the child coming into the UMFS TFC program. It should be completed at the time of initial and annual physical exams.

Child's Name: _____ **Date of COVID-19 Screening: _____**

Has the patient been in contact with anyone who has been suspected of having Coronavirus, or has cared for someone who has been suspected, within the last 14 days?	**Yes**	**No**	**If yes, specify the person(s) and level of contact:**

YES or NO, in the past 24 hours, has the patient reported exhibiting any of the following: *Note: as self-reported or as reported to doctor by the caregiver*	**Yes**	**No**	**Describe symptom and Onset**
Temperature (>100 F or higher)			
A cough (new or different)?			
Shortness of breath or difficulty breathing?			
Chills?			
Muscle Pain and/or body aches?			
Headache?			
New loss of taste or smell?			
Nausea, vomiting and/or diarrhea?			
Sore throat?			
Congestion or runny nose?			
New Rash?			

This COVID-19 screening was completed by or under the direction of a licensed physician.

_____

Signature & Title of Examiner

_____

Date of Examination

This form updated 6/4/2020 to be consistent w/ CDC & VDH guidelines

UMFS

REPORT OF TB SCREENING

Name: _____ Date of Birth: _____

TO WHOM IT MAY CONCERN:

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

_____ 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.

_____ A tuberculin skin test (PPD) was administered on _____ and results, read on _____, were as follows:
_____ mm _____ Negative _____ Positive.

_____ 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/Title: _____ Date: _____
(MD/designee or Health Department Official)

Print Name/Title: _____ Phone: _____

Address: _____

_____

_____