

# Ariel Clinical Services

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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.

1<sup>st</sup> 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): \_\_\_\_\_

Expiration date is for all persons listed on this form  
Unless otherwise indicated here, the next health evaluation will be required in two years.

**2<sup>nd</sup> Applicant Name:** \_\_\_\_\_ Date of Birth \_\_\_\_\_

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:

\_\_\_\_\_

**Child's Name:** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent'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:

\_\_\_\_\_

\_\_\_\_\_

**Child's Name:** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent'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:

\_\_\_\_\_

\_\_\_\_\_