DEPARTMENT OF FAMILY SERVICES CLARK COUNTY

CLARK COUNTY
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1850 E. Flamingo Rd.
Las Vegas, Nevada 89119
(702) 455-8806

CLARK COUNTY NEVADA

FOSTER CARE PHYSICAL EXAM FORM

Applicant's Consent

(Examination must be current within one year of application, and completed by a licensed physician, physician assistant or advanced practice registered nurse indicating that the applicant is physically, mentally, and emotionally capable of caring for foster children)

I, _____, hereby give my permission to the undersigned physician to release complete information regarding my physical and emotional health, including records, any medications I am using, and any medical or psychiatric diagnoses to the _____(Insert Agency Name)_____ for the purposes of fostering. This information or follow up information can be collected over the phone, if needed, by the child welfare agency.

Signature of Applicant _____ Date _____

Applicant's Name _____ Age _____

HEALTH HISTORY

☐Emotional/Mental ☐Chronic Illness ☐Degenerative Condition

Please list any conditions: _____

Physical Examination

TO EXAMINING PHYSICIAN: In evaluating the applicant, this agency must be guided by your findings as reported on this form. It is necessary to determine if the applicant is capable physically and emotionally of carrying out the responsibilities of caring for children.

Type of Exam/Provider: ☐Physical ☐Mental Date of Examination: _____

General Health: ☐Excellent ☐ Good ☐ Fair ☐ Poor

Evaluate the applicant's CURRENT physical/mental health:

_____

_____

_____

List any additional provider(s):

_____

_____

List/describe any CURRENT medication (prescription and non-prescription):

_____

_____

Name of prescribing doctor(s):

_____

Describe any physical limitation(s):

_____

_____

_____

Do you have any follow-up recommendations for this person regarding their health? ☐Yes ☐No

If yes explain _____

_____

_____

Conclusion

1. How long have you known the applicant? _____

2. What is your recommendation regarding the applicant's physical and emotional fitness to care for a child?

_____

_____

_____

3. If you know the applicant well enough, please give your impression of applicant's characteristics in terms of qualifying as a foster parent

_____

_____

_____

Would you recommend this applicant as a foster parent? ☐Yes ☐No

Signature of Examining Physician: _____

Printed Name of Physician: _____

Date: _____ Telephone: _____

Thank you for your participation. Please contact _____(Insert Agency Name)_____**at** _____(Insert Number)_____ **with any questions or comments.**