COLORADO
Office of Children, Youth & Families
Division of Child Welfare

FOSTER HOME AND ADOPTIVE HOME HEALTH ASSESSMENT FORM

Patient Name: _____

Patient Birthdate: _____ Date of Examination: _____

Length of Time you have known Patient: _____

Licensed Health Care Name/Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I, _____ _____
(Signature of Parent/Guardian of Child/Youth) (Address)

_____ hereby give my permission for release to the
(Telephone Number)

_____ County Department of Human/Social Services or Child Placement Agency, complete information about the condition of my child's (for Parent/Guardian) physical, emotional, and mental health.

General Condition of Health: ☐ **Good**- no concerns ☐ **Fair**- minor concerns

☐ **Poor**- several health concerns ☐ **Chronic**-chronic health concerns

Please describe General Condition of Health if the rating above is marked Poor or Chronic:

Patient is receiving treatment for a Chronic Illness/Condition? ☐ **Yes -** If "yes" please identify the condition below. ☐ **No**

Chronic Illness/Condition	Diagnosis/Prognosis:

Is the Patient Prescribed Medication(s)? ☐ **Yes -** If "yes" please list below. ☐ **No**

Medication Prescribed:	**Prescribed to Treat:**

ADULT SECTION RELATED TO VACCINATION(S):

Patient is current with the following vaccinations: See Vaccinations Listed Below

Vaccination(s):	Current:	Date Expires:
Influenza	☐ Yes ☐ No ☐ N/A	
Tdap	☐ Yes ☐ No ☐ N/A	
If "NO" is/are the vaccine(s) medically contraindicated for this Adults?	☐ Yes ☐ No	

CHILD SECTION RELATED TO VACCINATIONS:

Patient is current with ALL vaccinations recommended by the CDC* and ACIP*: ☐ Yes ☐ No ☐ NA

If "No", indicate which vaccination(s) is/are Not current:	Date Due

§26-6-911(2)(g) C.R.S., requires the certifying agency to have a health assessment of foster care parents completed by a licensed healthcare professional with a written evaluation of the person's physical and mental ability to care for children/youth in foster care.

In your opinion, is there any identified emotional, mental health, substance abuse, or physical conditions of this patient that could adversely affect children/youth who would be directly in contact with this patient?

☐ **Yes -** If "yes" please identify the concern(s) and any recommendations. ☐ **No**

Concern(s):	Recommendation:

What is your impression of the patient's emotional capacity and their ability to provide support, care, and healthy interactions with children/youth in foster care?

Date of next Health Assessment: _____

The time frame between health assessments cannot exceed two (2) years

Examining Physician, Doctor of Osteopathic Medicine, Physician Assistant, or Nurse Practitioner

_____ _____

Signature **Date of Report**

The report should be sent as requested below:

☐ **Please mail the completed form(s) in an envelope marked "CONFIDENTIAL" to:**
_____ **County Department of Human/Social Services or the Child Placement Agency (CPA) identified.**

Attention: _____

Address: _____

_____

☐ Encrypted and scanned to: _____

☐ Faxed to: _____