



**THERAPEUTIC FOSTER CARE  
PARENT EXAMINATION FORM**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

**PHYSICAL EXAM:** (Check box if normal. Explain if any evidence of abnormality.)

- Vision \_\_\_\_\_
- Hearing \_\_\_\_\_
- Heart \_\_\_\_\_
- Lungs \_\_\_\_\_
- Abdomen \_\_\_\_\_
- Kidneys \_\_\_\_\_
- Other \_\_\_\_\_

The health and stamina of this person is able to handle the stress of caring for foster children.       YES       NO

If no please explain \_\_\_\_\_

\_\_\_\_\_  
(Attach Laboratory Reports as applicable)

**GENERAL CONDITION (detailed)** \_\_\_\_\_

Current Medications \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Physician Name (printed)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address

(This form may be used by the Physician in lieu of a narrative or other type report form.)