

Health Report for Foster and Adoptive Parents

If family members are under the care of separate practitioners, complete a form for each member. The family should complete Part C before visiting the health practitioner.

A. To the health practitioner:

The family named below plans to give care to children and has been asked to obtain this statement from their health practitioner. Your assistance in verifying the fact that the family members are in sound physical and mental health will assist us in completing the study of this family. Thank you.

Contractor Licensing Worker's Signature

| | | | |
|---------------|--------|---------------|----------|
| Father's Name | | Mother's Name | |
| Children | | | |
| Street | | | |
| City | County | State | Zip Code |

B. Health practitioner's statement:

- On the basis of my examination of the members of this family, each member is in sound physical and mental health and there is no evidence of any communicable or infectious disease which would be detrimental to the well-being of a child placed in this home. The family's health would not prevent them from providing needed care to children.
- The following problems prevent me from signing the statement above and cause me to recommend against licensing as a foster family home or approval as an adoptive family.

Health Practitioner's Signature

Date

C. To be completed by family before visiting health practitioner:

Does any member of your family have a history of any of the following? Check yes or no. If yes, indicate each affected person's name.

| <u>Yes</u> | <u>No</u> | <u>Name of Person Affected</u> |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (specify) |

Has any member of your family had operations, broken bones, or serious accidents during the past two years? If so, describe below:

| Type of Incident | Person Involved | Approximate Date |
|------------------|-----------------|------------------|
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I agree that all findings of the examination be submitted to the Iowa Department of Human Services and

| | |
|---|------|
| (Name of licensed child placing agency, if appropriate) | |
| Signed | Date |