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 Patient/Parent/Guardian of Child/Youth) (Address)

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

Envoi Associates
_____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): Optional

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: Optional

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

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?

Unless a shorter time frame is indicated, the next health evaluation will be required in three (3) years.

The time frame between health assessments cannot exceed three (3) 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: _____

[X] Encrypted and scanned to: cmoore@envoiassociates.com

[X] Faxed to: 888-251-2618, Attn: Candice Moore