



CERTIFICATE OF HEALTH ASSESSMENT FOR FOSTER CARE PROVIDERS' OWN CHILDREN

Complete this section of the form for each child under age 16 residing in the foster home, excluding foster children.

Child's Name _____ Date of Birth _____ Sex _____
 Parent(s) Name(s) _____
 Address _____
 Street _____ City _____ Zip Code _____

Please give dates for ALL immunization series completed by your child in the space below. Record MM/DD/YY. Update this for each time immunizations are given.

		1	2	3	4	5
Single Dose Only	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /	/ /		
	RUBEOLA (MEASLES)	/ /	/ /	/ /		
	MUMPS	/ /	/ /	/ /		
	RUBELLA (GERMAN MEASLE)	/ /	/ /	/ /		
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

The section is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES _____
 CURRENT MEDICATIONS _____
 NUTRITIONAL STATUS _____

HEIGHT _____ WEIGHT _____

PHYSICAL EXAMINATION

HEAD _____	ABDOMEN _____
EENT _____	GU _____
TEETH _____	GYN _____
HEART _____	SKELETAL _____
LUNGS _____	NEUROLOGICAL _____

SCREENING TESTS (DATES DONE AND RESULTS/DO AS NEEDED)

VISION _____	TBC TEST _____
HEARING _____	SICKLE CELL _____
SPEECH _____	HGB _____
DDST _____	UA _____

OTHER _____

DIAGNOSIS: _____

RECOMMENDATIONS _____

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION? YES _____ NO _____

DOES THIS CHILD HAVE ANY BEHAVIORAL OR HEALTH PROBLEMS WHICH WOULD PRECLUDE A FOSTER CHILD FROM BEING SAFELY PLACED IN THIS HOME? YES _____ NO _____

Date _____

Signature of Licensed Physician or Nurse approved to perform health assessments