NORTHERN VIRGINIA FAMILY SERVICE

Health Statement—Foster/Respite Family Member

Full Name: _____ DOB: _____

Hair color _____ Color of eyes _____

Weight: _____ Height: _____

Physician: All questions must be answered.

1. Assess the individual's current physical health status._____
2. What is the mental health status of this individual?_____
3. What, if any, chronic conditions, serious illness(es), surgeries or hospitalizations has the patient experienced in the last ten years? _____

   _____

   _____
4. What medications does the patient regularly take? _____

   _____
5. Does the patient have any condition that would adversely affect the care or condition of foster/respite children in their home? **Circle**: Yes No

   _____
6. What specific tuberculosis test was administered? _____
7. Date tuberculosis test was administered. _____
8. What was the result of the tuberculosis test? _____
9. Is the applicant free from tuberculosis in a communicable form? _____
10. If no test was administered in the past 12 months, explain_____

    _____

_____ _____

Signature of Physician **Date**

Printed Name of Physician_____

Address: _____

_____

Telephone Number: _____