STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

 RESOURCE FAMILY APPROVAL

**Health Screening for: ABRAZO FOSTER FAMILY AGENCY**

Purpose of Form: To verify applicant’s physical health. Must be completed by a licensed health professional.

|  |  |
| --- | --- |
| Applicant Name: (first, middle, last) | Date of Birth: |

Please provide listing of current licensed health professionals (Name, Address, and Telephone Number)

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release of Information: I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release the medical information contained on

 (Doctor’s name)

this form, to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for the purposes of determining my physical health.

 (County/Agency)

|  |  |
| --- | --- |
|  Patient Signature | Date : |

**I. Medical History:** (check any that apply and provide comment):

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|  |  |  |
| --- | --- | --- |
| □ Heart Disease | □ Impaired Sight | □ Orthopedic Problems |
| □ Cancer | □ Heredity Conditions | □ Chronic Medical Conditions |
| □ Diabetes | □ Hypertension | □ Mental Illness |
| □ Impaired Hearing | □ Allergies | □ Respiratory Condition |
| □ Seizure Disorder | □ TB screen □ test □ neg □ positive □ xray |
| □ Other- |

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**Comment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tobacco Usage**

Do you smoke nicotine cigarettes? \_\_\_\_\_\_\_\_\_\_ If so, how many packs per day? \_\_\_\_\_\_\_\_\_\_

**Alcohol Consumption**

How many alcoholic beverages do you consume daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Limits or restrictions on physical activity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**II. Physical Examination:**

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments and Diagnoses**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**III. Medications**

(Please list all medications the patient is currently taking including medical marijuana.

Additional medications can be listed in an attachment.)

|  |  |
| --- | --- |
| Name of Medication | Dose and Condition Prescribed For: |
|  |  |
|  |  |
|  |  |

**IV. Additional Comments by Licensed Health Professional**

(Please note any health condition that may create a risk to the health or safety of the patient, children, or others in

the patient’s care)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**V. Certification**

I certify that I completed the health screening on this patient for the purpose of verifying the patient’s

physical health.

|  |  |
| --- | --- |
| Date Examined | Signature of Licensed Health Professional |
| Telephone Number | Printed Name of Licensed Health Professional |
| Address of Licensed Health Professional |

**Reminder to Applicant:** Please return the completed RFA Health Screening to your assigned

RF worker.

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