Health Statement
Permanent Member
Foster Family Household

Name of Foster Family: ____

Address: ____

Name of Household Member: ______________________________________

NOTE TO PHYSICIAN:

1. Please evaluate the household member's current health status: ______________________
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____

2. Please indicate whether the household member is free from tuberculosis in a communicable form and include the type(s) or test(s) used and the results: ___________________________
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3. Please indicate whether, in your opinion, the health of the household member will or will not affect the care of foster children: ____
____
____

4. Comment/Recommendations: ____
____
____

Signed: ______________________________ Date of Evaluation: ______________
Physician/Designee

Name: ___________________________________

Address or Office Stamp: ____

Phone Number: ______________________________