Print Form

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
Children with Developmental Disabilities

Physician's Report
DD Child Foster Home

Section I -- To be completed by provider/co-provider/applicant:

I, _____, hereby authorize the release of my medical information to the Department of Human Services, Seniors and People with Disabilities (DHS/SPD), and the DD Program Certifier. I understand that the information received will remain confidential and any concerns found will be discussed confidentially with the certifier.

_____ _____
Provider/co-provider/applicant signature Date

Section II – To be completed by the DD Program Certifier:

Mr./Mrs./Ms. _____ DOB: _____ has applied for certification as a child foster care provider with DHS/SPD. Information on the health of this applicant is required for certification, and an important part of the investigation of the home. The physician may require a general physical examination if the physician feels that sufficient medical information is not available. Please complete this form and return it to:

Foster care certifier: _____
Address: _____
FAX number: _____

Section III – To be completed by physician:

1. How long has the individual above been under your care? _____
2. Date of last examination: _____
3. Does the individual named above have the history or present evidence of physical or mental illness, drug or alcohol abuse or serious operations or injuries that, in your opinion, would hinder them in the care of children? ☐ Yes ☐ No
4. Please list all current medications this individual is taking:

Name of medication		Dosage

5. To your knowledge, does this person, or any member of the household have a Communicable disease? ☐ Yes ☐ No

   If yes, please describe:

_____

_____

_____

_____

_____

6. Does this patient suffer a communicable disease, specific illness or disability that would interfere with the family's ability to care for children in foster care? ☐ Yes ☐ No

It is my opinion that this patient is physically and mentally able to perform the duties of a foster care provider. ☐ Yes ☐ No

Physician's name: _____

Complete address: _____

Phone number: _____

_____ _____

Signature Date