DHS-1995-ENG (3-91)

Physician's Report

☐ Adult Foster Care ☐ Child Foster Care ☐ Family Day Care

I. Authorization for Release of Medical Information

I authorize my physician or clinic to release any medical information pertinent to my application for or employment within the residence of a Family Day Care or Child Foster Care or Adult Foster Care Home.

_____ _____

Signature of individual on whom the information is requested *Date*

II. Identifying Information

Last Name:	First Name:			Birthdate:
Address:	City:	State:	Zip Code:	Relationship to provider:

III. To the Examining Physician:

In the best interest of the provider and the children and/or adults in care, good health is a factor in the selection of homes.

A. How long has the above named individual been under your care? _____

B. Date of last examination _____

C. Does this person have a history or present evidence of a serious operation, injury, or physical or mental illness which in your opinion would hinder him/her in the care of children and/or adults? Please explain. _____

D. Does this person have any communicable diseases? _____

E. Is this person taking any medications which may affect their ability to provide care? If so, what? _____

F. Does this person have a history or present evidence of chemical abuse/dependency? Please explain. _____

G. Is there another physician with whom we should consult before making a decision about this person's application? ☐ Yes ☐ No
If yes, please give name and phone number of physician. _____

H. In your opinion, is his/her health suitable to provide care? ☐ Yes ☐ No

Signature of examining physician:	Date:	Telephone #:

Physician's address:	City:	State:	Zip Code:

NOTICE TO THIRD PARTIES - Minnesota Statutes, Sec. 13.04 allows recipients access to recorded data. Be informed that upon request of the recipient or his or her legal representative, this Department is required to provide them the information contained on this form. Any statements included in the client's file may be opened to his or her inspection.