

Please give your impression of this person's health status, both physical and emotional, and general prognosis for continued well-being. If this person is a child, is the child up to date with immunizations?

Is this person free from communicable disease? Yes No. If no, please comment:

Do you consider this person's physical and emotional condition satisfactory to provide foster care or to adopt a child? Yes No. If no, please comment:

SIGNATURE

Name of Physician:	Physician's Signature:	Date:
Address: (No. and Street):	City:	State: Zip:
Office Phone #:	E-mail:	

SEND COMPLETED FORM TO:

Fax or mail copies to: Department of Children and Families FASU	Fax #:
Address:	
Address 2:	
City	State Zip
Attention:	