RESOURCE FAMILY APPROVAL

Resource Family Approval (RFA)

Health Screening for County/Agency: Our Small World 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 _____ (Doctor's name) to release the medical information contained on this form, to the Our Small World FFA (County/Agency) for the purposes of determining my physical health.

Patient Signature	Date

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

☐ 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-		

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: _____

II. Physical Examination:

Height: _____ Weight: _____ Blood Pressure: _____

Comments and Diagnoses

_____

_____

_____

_____

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)

_____

_____

_____

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.