Washington County

Community Services

WCCS-71980-49 (3-13)

Adult Foster Care

History & Physical Examination Form

Client: ______________________ **DOB:** ______________

Adult Foster Care Provider: ______________________ Telephone: ______________

Address: ____

Physician: ______________________ Telephone: ______________

Clinic Name: ____

Address: ____

Authorization for Release of Medical Information

I authorize my physician or clinic to release medical information pertinent for my placement in ______________________ adult foster care home to the following:

______________________________ ______________________

Signature of Resident/Guardian Date

1. **Medical History & Physical: Physician Please Complete:**
   (Please attach print out of physical exam.)

   Date Examined: ____

   Medical Diagnosis: ____

   Past Surgeries: ____

   History: *(Check those that apply)*

   - ☐ Arthritis
   - ☐ Diabetes
   - ☐ Hypertension
   - ☐ Endocrine Disorders
   - ☐ Cancer
   - ☐ Mental Illness
   - ☐ Diagnosis: ______________________
   - ☐ Congenital Disorders
   - ☐ Chemical Dependency
   - ☐ Other: ______________________

   Allergies: ____

   Physical Disabilities: ____

   ____

   Activity Recommendations/Limitations: ______________________________

   ____

2. **Mental Status:**

Alert:	☐ Yes	☐ No	Forgetful:	☐ Yes	☐ No
Orientated to person:	☐ Yes	☐ No	Confused:	☐ Yes	☐ No
Orientated to place:	☐ Yes	☐ No	Able to direct own cares:	☐ Yes	☐ No
Orientated to time:	☐ Yes	☐ No			

Assessment/Comments: ______________________________

____

3. **Date Mantoux Administered:** ____________ Results: ______________________

4. **Vaccinations:**
   Date of Last Tetanus: ____________
   Has client received Pneumococcal vaccine? ☐ Yes ☐ No Date: ____________
   Has client received Hepatitis B vaccine? ☐ Yes ☐ No Date: ____________
   Any other recommended vaccines? ______________________

5. **Does client require any special medical treatments?** ☐ Yes ☐ No

____

6. **Client is free of communicable disease:** ☐ Yes ☐ No

____

7. **Diet:** ____________ Restrictions: ______________________

8. **Any contraindications to over-the-counter medication:** ☐ Yes ☐ No

____

____

9. **This client is appropriate for adult foster care?** ☐ Yes ☐ No

____

10. **New Orders for Treatments/Referrals:** ______________________

____

____

11. **Date of Next Visit:** ____________

On the basis of this examination, it is my finding that the above person is essentially free from medical conditions and communicable diseases which might endanger other foster home residents.

____
Physician's Name (Print)

______________________________ ______________________
Physician's Signature Date