

"Providing Opportunity and Direction for Children, Youth and Families"

**Health Statement – Foster Family Household**

Name: \_\_\_\_\_

Date of examination: \_\_\_\_\_

Bishop John R. Schol  
Baltimore-Washington Conference

Bishop Peggy A. Johnson  
Peninsula-Delaware Conference

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Ted M. Jackson  
Arthur R. Ransom, Jr.

**MEDICAL HISTORY (Please check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Alcoholism                        | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Allergies                         | <input type="checkbox"/> Hypertension       |
| <input type="checkbox"/> Arthritis                         | <input type="checkbox"/> Kidney Disorder(s) |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Mental Disorder(s) |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Migraines          |
| <input type="checkbox"/> Colitis                           | <input type="checkbox"/> Pelvic Disorder(s) |
| <input type="checkbox"/> Deafness                          | <input type="checkbox"/> Substance Abuse    |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Disease of the Circulatory System | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Disease of the Nervous System     | <input type="checkbox"/> HIV                |
| <input type="checkbox"/> Epilepsy                          | <input type="checkbox"/> Other              |

Please elaborate on the severity and length of illnesses: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any prescribed medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Surgeries/Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Accidents or Injuries: \_\_\_\_\_

\_\_\_\_\_

**PHYSICAL EXAMINATION:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Recommended Weight \_\_\_\_\_

**TB TEST MUST BE DONE AT TIME OF EXAM**

Chest x-ray \_\_\_\_\_ or TB test \_\_\_\_\_ (within six months):

Date: \_\_\_\_\_ Results: \_\_\_\_\_

3300 Gaither Road  
Baltimore, MD 21244-2999  
Phone (410) 922-2100  
1-800-CARE-734  
FAX (410) 922-4830  
Website: boardofchildcare.org  
E-mail: info@boardofchildcare.org



**LABORATORY TESTS:**

Other laboratory tests and results: \_\_\_\_\_

Impression of General Health \_\_\_\_\_

Please indicate any recommendations for medical care \_\_\_\_\_

Please comment on any physical or mental conditions (including addictions) and whether they will affect the care of foster children:

Comments: \_\_\_\_\_

Signature of Examining Physician

Name (print)

Address

City                      State                      Zip Code

Telephone Number