TWIN PINES FAMILY SERVICES, LLC

1 Washington St. Suite A. Hopwood, PA. 15445 Office: 724-439-HOME
www.twin-pines.org Fax: 724-439-4664

FOSTER PARENT MEDICAL REPORT

This examination is required to determine whether the health of a prospective foster parent will permit him or her to accept a foster child into his or her home. Current health, past health, as well as prognosis for future health should be considered. This medical information is for the use of Twin Pines Family Services, LLC only. Fill out completely. No form filled out by Med Express will be accepted. Test results *only* may be accepted from Med Express if they cannot be completed through a regular PCP. Twin Pines Family Services, LLC reserves the right to require additional medical testing and/or a renewed physical upon request as per policy.

Patient's Name: ____________________________________ Date of Birth: __________________
Address: ____
Weight: ___________ Height: ___________ Heart: ___________ Lungs: ___________
Blood Pressure: ____________ General Vitality Level: ___ High ___ Moderate ___ Low
TB Test or chest x-ray: ___________ Date Given: ___________ Date Checked: ____________
Mental/Emotional concerns: ____
Medical findings/prognosis for continued health: ____
History of hospitalizations: ___ No ___ Yes
For what/when: ____________________________________
____
____

History of surgeries: ___ No ___ Yes
For what/when: ____________________________________
____
____

Referral to any specialist: ___ No ___ Yes ____________________________________

Please comment if there are any physical, mental, and/or emotional problems/concerns (past or present) that the agency should be aware of in considering patient for approval:
____
____
____

How long have you known the patient and/or the family? ___________________________________
The patient is free from communicable disease(s): ___ No ___ Yes
The patient is emotionally capable of carrying out parenting duties: ___ No ___ Yes
The patient can perform duties associated with parenting: ___ No ___ Yes
The patient is physically capable of lifting small children: ___ No ___ Yes
Medication List: ____
____

Date of Examination: _______________
Physician Print: _________________________ Physician Signature: _________________________
Office Address: _____________________________ Office Phone Number: _________________
_____________________________ Office Fax Number: ___________________