FCL 059
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KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES

Foster Care Licensing and Background Checks Division
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Kansas Department for Children and Families

CERTIFICATE OF HEALTH ASSESSMENT FOR FOSTER CARE PROVIDERS' OWN CHILDREN

Complete this section of the form for each child under age 16 residing in the foster home, excluding foster children.

Child's Name _____ Date of Birth _____ Sex _____

Parent(s) Name(s) _____

Address _____ _____ _____
Street City Zip Code

Please give dates for ALL immunization series completed by your child in the space below. Record MM/DD/YY. Update this for each time immunizations are given.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /	/ /		
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /	/ /		
	MUMPS	/ /	/ /	/ /		
	RUBELLA (GERMAN MEASLE)	/ /	/ /	/ /		
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

This section is to be completed and signed by a nurse approved by DCF to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES _____

CURRENT MEDICATIONS _____

NUTRITIONAL STATUS _____ HEIGHT _____ WEIGHT _____

PHYSICAL EXAMINATION

HEAD _____ ABDOMEN _____

EENT _____ GU _____

TEETH _____ GYN _____

HEART _____ SKELETAL _____

LUNGS _____ NEUROLOGICAL _____

SCREENING TESTS (DATES DONE AND RESULTS/DO AS NEEDED)

VISION _____ TBC TEST _____

HEARING _____ SICKLE CELL _____

SPEECH _____ HGB _____

DDST _____ UA _____

OTHER _____

DIAGNOSIS _____

RECOMMENDATIONS _____

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION? ☐ YES ☐ NO

DOES THIS CHILD HAVE ANY BEHAVIORAL OR HEALTH PROBLEMS WHICH WOULD PRECLUDE A FOSTER CHILD FROM BEING SAFELY PLACED IN THIS HOME? ☐ YES ☐ NO

_____ _____
Date **Signature of Licensed Physician or Nurse approved to perform health assessments**