FCL. 009
Rev. 06/24

Kansas Department for Children and Families
Foster Care Licensing and Background Checks Division
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CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons living in a Family Foster Home [K.A.R. 30-47-819] must have a health assessment.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

_____ _____
Name of the facility (exactly as stated on the license) License #

_____
Street Address City Zip Code County

Check type of child care facility:

☐ Attendant Care Facility ☐ Group Boarding Home ☐ Secure Residential Treatment Facility
☐ Detention Center ☐ Staff Secure Facility ☐ Secure Care Center
☐ Family Foster Home ☐ Residential Center ☐ Juvenile Crisis Intervention Center

Name of Foster Parent/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.	Yes	No
1. Do you see a physician regularly for any health condition?	☐	☐
2. Are you taking any medication regularly?	☐	☐
3. Have you had any surgery in the past 3 years?	☐	☐
4. Do you have any handicapping conditions which might interfere with the care of children?	☐	☐

5. Do you have any chronic illness conditions such as:

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Cancer	☐	☐	Alcoholism	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Convulsions	☐	☐	Liver Disease	☐	☐
Lung Disease	☐	☐	Mental Illness	☐	☐	Other	☐	☐

If Other, Describe: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

Record results of TB test or attach results to this form.

Negative tuberculin test ☐ or negative chest x-ray ☐ on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____ _____
Licensed Physician/Nurse Signature or Health Department **Date (MM/DD/YYYY)**