

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.

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
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:								
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)