OCFS-LDSS-0738 (Rev. 11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICAL HISTORY OF PROSPECTIVE OR CERTIFIED FOSTER PARENT(S)

NAME OF FOSTER PARENTS(S):
ADDRESS OF FOSTER PARENT(S):

NOTE: Physician should mail directly to:

Part 443 of New York State Department of Social Services regulations requires an authorized agency to arrange for a medical report form to be filled with the agency "either prior to acceptance for a home study or after acceptance for a home study. The medical report form shall cover a physical examination of the applicant(s) and shall include a written statement from a physician regarding the foster family's general health, the absence of communicable disease, infection or illness or any physical conditions which might affect the proper care of a foster child. It shall include also the result of an intradermal tuberculin test and an additional report of chest x-rays where such test is positive. For foster parents seeking recertification from an authorized agency, pursuant to 18NYCRR 443.10(a) (3) shall obtain "a written statement from a physician about the foster family's or relative family's health, if it has been two years since the date of the last medical exam, conforming to the standards set forth in this Part".

Physician's Statement on the Family's General Health, etc.

RESULTS OF TUBERCULIN TEST:	DATE:
RESULT OF CHEST X-RAYS:	DATE:

On the basis of my findings, as indicated above, and my knowledge of the applicants and their family, I find that the above listed applicant(s) are/is physically

☐ FIT to give adequate care for foster children

☐ UNFIT

PHYSICIANS SIGNATURE:	DATE: