DPP-107
(R. 10/15)
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Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
Division of Protection and Permanency

HEALTH INFORMATION REQUIRED FOR FOSTER OR ADOPTIVE PARENTS, APPLICANTS, OR ADULT HOUSEHOLD MEMBERS

Name (First, Middle, Last) Date of Birth Sex

Address: Street City State Zip Code

The individual named above is a: Foster/adoptive applicant: ________ Adult household member of a Foster/adoptive applicant: _________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize the release of this information for the limited purpose of my application as a foster/adoptive parent.

Signature of the Foster/Adoptive Applicant Date

THIS SECTION TO BE COMPLETED BY THE HEALTH PROFESSIONAL

As part of the application process for approval as a foster or adoptive parent, to include adult household members, a statement from a physician, physician's assistant, advanced practice registered nurse, or registered nurse under the supervision of a physician, is required to address the following:

1. Do you have reason to believe the applicant [or adult household member(s)] has a communicable or infectious disease **that would present a health or safety risk to a child placed in the applicant's home**? ☐ **YES** ☐ **NO**

2. (a) Has the applicant [or adult household member(s)] previously had or does the applicant [or adult household member(s)] currently have a medical condition that would present a health or safety risk to a child placed in the applicant's home? ☐ **YES** ☐ **NO**

   (b) Do you have reason to believe that the applicant [or adult household member(s)] has a medical condition that would present a health or safety risk to a child placed in the applicant's home? ☐ **YES** ☐ **NO**

   (c) If **YES to either [(a) or (b)],** please report the nature of condition or suspected condition: ________________________________
   ____

3. (a) Does the applicant have a physical limitation, mental illness, alcohol or drug problem, significant history of physical or mental illness, or other health condition that would interfere with the applicant's ability to provide satisfactory foster/adoptive care?
   ☐ **YES** ☐ **NO**

   (b) If **YES,** please report the nature of condition: ________________________________
   ____

4. (a) Does the applicant currently take prescription medication? ☐ **YES** ☐ **NO**
   (b) If **YES,** please list name(s) of prescription medications currently taken by the applicant including dosage and condition(s) for which the medication is taken:

Medication:	Dosage and Frequency	Condition for which medication is prescribed

5. (a) Would responsibility for a foster/adoptive child pose a potential risk to the applicant's health? ☐ **YES** ☐ **NO**

   (b) If **YES,** please explain:______________________________

6. Date of applicant's most recent physical examination:______________________________

7. Are there issues of concern that you wish to discuss with a Cabinet for Health and Family Services representative? ☐ **YES** ☐ **NO**

HEALTH PROFESSIONAL'S STATEMENT: Based upon my knowledge of the individual(s) listed above and the health history reported by the applicant [or adult household member], I know of no health factors that would interfere with the applicant's ability to be a foster or adoptive parent.
Comments: ______________________________

____

____
Physician's/Health Professional's Signature　　　Title　　　Date

____
Address　　　Phone Number

THIS SECTION TO BE COMPLETED BY THE APPLICANT/PATIENT

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

		YES	NO	COMMENTS
GENERAL:				
	Migraines or severe headaches	☐	☐	
	Seizures, Convulsions, Epilepsy	☐	☐	
	Diabetes, Sugar in Blood or Urine	☐	☐	
	Unusual Lumps	☐	☐	
	Arthritis, Joint Pains, Gout	☐	☐	
	Emotional Problems, Depression	☐	☐	
	Attempted Suicide	☐	☐	
EYES:	Blurring, Changing Vision	☐	☐	
	Glaucoma, Cataracts	☐	☐	
EARS:	Trouble Hearing, Ringing	☐	☐	
HEART:	Chest Pain, Shortness of Breath	☐	☐	
BLOOD/CIRCULATION:				
	High Blood Pressure	☐	☐	
	Stroke	☐	☐	
	Varicose (Swollen) Veins	☐	☐	
	Blood Clots in Leg, Lung	☐	☐	
	Transfusions	☐	☐	
	High Blood Cholesterol or Fat	☐	☐	
RESPIRATORY:				
	Asthma, Pneumonia, Emphysema	☐	☐	

THIS SECTION TO BE COMPLETED BY THE APPLICANT/PATIENT

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO	COMMENTS
LIVER: Hepatitis, Jaundice, Cirrhosis	☐	☐	
GALLBLADDER: Disease, Stones	☐	☐	
ABDOMEN: Ulcer, Pain	☐	☐	
BOWELS: Polyps, Blood in Stool	☐	☐	
KIDNEY OR BLADDER: Blood/Pus in Urine	☐	☐	
Frequent Infections	☐	☐	
Stones	☐	☐	
EXTREMITIES (Arms, Hands, Legs, Feet):			
Loss of Feeling, Tingling, Burning	☐	☐	
Pain, Swelling, Tenderness	☐	☐	
Amputation	☐	☐	
SEXUALLY TRANSMITTED DISEASE:	☐	☐	
CANCER:	☐	☐	
OTHER: Unlisted Symptoms or Health Conditions	☐	☐	

SURGERIES OR HOSPITALIZATIONS (INCLUDE OUTPATIENT):

______________________ DATE__________ HOSPITAL ______________________

______________________ DATE__________ HOSPITAL ______________________

______________________ DATE__________ HOSPITAL ______________________

LIFESTYLE:

How often do you exercise? ______________________

Have there been any recent or stressful events to you or your family? ☐ **YES** ☐ **NO** If yes, please describe:______________________

____

Do you or have you ever used tobacco products? ☐ **YES** ☐ **NO** If yes, how often? ______________________

What type (e.g. cigarettes, chew etc.)? ______________________

Do you or any household members smoke inside the home? ☐ **YES** ☐ **NO**

Do you drink alcoholic beverages? ☐ **YES** ☐ **NO** If yes, how often? ______________________

Do you use illicit drugs (marijuana, etc.)? ☐ **YES** ☐ **NO** If yes, which drugs? ______________________

Do you wear a seat belt on a regular basis? ☐ **YES** ☐ **NO**

____

SIGNATURE OF APPLICANT OR ADULT HOUSEHOLD MEMBER **DATE**