RESOURCE FAMILY APPROVAL
Health Screening Assessment

Instructions: Please type or print clearly.

RFA Applicant Name	RFA Applicant Signature	Date

Release of Information

I hereby authorize _____ to release the medical information contained on this form to the Health and Human Services Agency, Child Welfare Services, Resource Family Approval Unit, in consideration of becoming a Resource Family home.

Patient Signature	Date

Current Health Care Providers

Regular Medical Doctor: _____ Dentist: _____
Specialist: _____ Other: _____
Other: _____ Other: _____
List additional health care providers on reverse

Section I: Medical History

Check any that apply and provide comment:

☐ Heart Disease	☐ Hereditary Conditions	☐ Chronic Medical Conditions
☐ Cancer	☐ Hypertension	☐ Mental Illness
☐ Diabetes	☐ Allergies	☐ Respiratory Condition
☐ Impaired Hearing	☐ Orthopedic Problems	☐ Seizure Disorder
☐ Impaired Sight		

Smoking habits: _____	Alcohol consumption: _____
Date of last flu vaccine: _____	Date of last Tdap: _____

Comments: _____
_____
_____

Limits or restrictions on physical activity: _____
_____

Section II: Medications

Name of Medication	Condition Prescribed For

List additional medications on reverse.

Section III: Physical Screening

Height:	Weight:	Blood Pressure:
Date of TB test:	☐ Positive ☐ Negative	Action taken (if positive)

Section IV: Certification

I certify that I completed the health screening on this individual for the purpose of completing Resource Family Approval requirements.

Date Examined: _____	Signature of _____ Licensed Healthcare Professional
Address of Licensed Healthcare Professional: _____	
Telephone Number: _____	Printed Name of _____ Licensed Healthcare Professional

RFA Applicant Name	RFA Applicant Signature	Date

Additional Healthcare Providers	
Name of Health Care Provider	Specialty

Additional Medications	
Name of Medication	Condition prescribed for

Additional Comments:

_____
_____
_____
_____
_____