IOWA HHS

Iowa Department of Health and Human Services

Health Report for Resource Families

If family members are under the care of separate practitioners, complete a form for each member. The family should complete Part **B** before visiting the health practitioner.

A. To the health practitioner:

The family named below has applied for foster care licensure/adoptive approval to provide care to children and has been asked to obtain this statement from their health practitioner. Please include any concerns regarding their mental or physical health that would impair the applicant's ability to care for children. In regard to children in the household, please provide any physical or mental health concerns that would impact the parent's ability to care for other children coming into the home. Thank you.

Contractor Licensing Worker's Signature	Contractor Licensing Worker's Phone Number

Applicant Name	Applicant Name		
Children			
Street			
City	County	State	Zip Code

B. To be completed by family before visiting health practitioner:

Does any member of your family have a history of any of the following? Check yes or no. If yes, indicate each affected person's name.

Yes	No		Name of Person Affected
☐	☐	Seizures	
☐	☐	Hepatitis	
☐	☐	Whooping cough	
☐	☐	Skin disease	
☐	☐	Diabetes	
☐	☐	Heart disease	
☐	☐	High blood pressure	
☐	☐	Kidney disease	
☐	☐	Tuberculosis	
			Add any mental health diagnosis with check boxes
☐	☐	Other (specify)	

Does any member of your family take medications? If so, list their name, the medication, and the reason for each medicine.

Name	Medication	Reason

Has any member of your family had operations, broken bones, or serious accidents during the past two years? If so, describe below:

Type of Incident	Person Involved	Approximate Date

C. Health practitioner's statement:

☐ On the basis of my examination of (insert name(s)) there are no identified physical or mental health concerns would not prevent the applicant's ability to care for children. In regard to children in the household, there are no conditions that would impact the parent's ability to care for other children coming into the home. In addition, there is no evidence of any communicable or infectious disease which would be detrimental to the well-being of a child placed in this home.

☐ The following problems prevent me from signing the statement above and cause me to recommend against licensing as a foster family home or approval as an adoptive family.

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Health Practitioner's Signature	Date

I agree that all findings of the examination be submitted to the Iowa Department of Human Services and

(Name of licensed child placing agency, if appropriate)	
Signed	Date