Children's Services of Virginia, Inc.
P.O. Box 1069
Harrisonburg, VA 22803
Phone: (540) 801-0900 FAX: (540) 801-0886

HEALTH STATEMENT—FOSTER/ADOPTIVE FAMILY

Name:____

Note to Physician:

1. Please evaluate the individual's current physical and mental health status. Please elaborate if there are concerns:

____

____

____

2. Please indicate if there are symptoms of TB for this individual, necessitating a test:
Yes_____ No_____.
If testing is administered, please describe:
   - The type of test used ____
   - The results ____
   - The date of the results __________________________

3. Please indicate whether, in your opinion, the health of the individual will or will not affect the care of special needs foster children:

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____

4. Comments/Recommendations:____

____

____

Date of Evaluation:______________________________

Signed:____
Signature (Physician) Print Name

____
Signature (Physician Designee) Print Name

____
Signature (Health Department Official) Print Name

Revised 1/2/2007