COUNTY COMMISSIONERS
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COUNTY OF MERCER
CHILDREN AND YOUTH SERVICES

Medical Appraisal

The following individual is an applicant or current resource parent in need of a physical examination necessary to fulfill Pennsylvania's resource parent regulations verifying that this person is free of communicable diseases, is in reasonable heath, is about to provide care and supervision to children in foster care, and is physically and emotionally capable of carrying out the responsibilities of complete parental duties.

This form must be completed by the examining physician. Please type or print clearly the following information as completely and precisely as possible. The cost of the examination is to be met by the individual.

Name: _____ Age: _____
Sex:_____Height:_____Weight:_____Blood Pressure:_____

Please indicate if the individual has history or current concerns within the following areas:

Physical Condition	**Provide detail of timeframe of Dx, treatment, current concerns**
Diabetes	
Heart Condition	
High Blood Pressure	
High Cholesterol	
Epilepsy/Seizure Disorder	
Sickle Cell	
Emphysema	
Asthma	
Allergies	
Cancer	
Other	

Emotional Condition	**Provide detail of timeframe of Dx, treatment, current concerns**
Mental Health (Inc Dx)	
Alcohol Dependence	
Substance Dependence	
Other	

Please indicate history of treatment for this individual not otherwise specified above:

Treatment	**Provide detail of timeframe, type, and circumstances surrounding treatment**
Hospitalizations	
Out-patient services	
Partial Programs	
Medications	
Other	

Provide comments regarding physical and/or emotional condition at the time of examination. Please include in your professional opinion, any limitation that should be considered when placing a child in this person's care and home:

_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify that I have carefully examined _____ on this _____ day of _____, 20____, and he/she was found to be free of any communicable diseases, specific illness or disability which may pose a significant risk of transmission in the home.

Signature of physician: _____
Print name of physician: _____
Physician's address: _____
Physician's Phone: _____