Adolescent and Family Growth Center, Inc.
8000 Forbes Place, Suite 201
Springfield, Virginia 22151

HEALTH STATEMENT PERMANENT MEMBER
FOSTER FAMILY HOUSEHOLD

FOSTER FAMILY NAME: _____

ADDRESS:_____

_____

NAME OF HOUSEHOLD MEMBER: _____

NOTE TO PHYSICIAN:

1. Please evaluate the household member's current health status:

_____

_____

_____

2. Please Indicate whether the household member is free from tuberculosis in communicable form and include the type(s) of test(s) used and the results:

_____

_____

_____

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

_____

_____

_____

4. Comments/Recommendations:

_____

_____

Date of Evaluation: _____ Signed: _____

Physician