



Health Check Form

Foster Parent Applicant Name _____

Foster Parent Co-Applicant Name _____

s. DCF 56.04 (4):

2. The applicant for an initial license to operate a foster home shall provide documentation of the applicant's good health by presenting to the licensing agency a written statement from a physician, physician assistant or nurse practitioner that, based upon a medical examination performed within the previous 6 months, the applicant does not have any illness or disability that is likely to threaten the health of foster children or interfere with the applicant's capacity to provide care.

In accordance with s. HFS/DCF 56.04 (4), I verify that the above named individual(s) are in overall good health, have had a medical examination within the previous 6 months, and do not have any illness or disability that is likely to threaten the health of foster children or interfere with the applicant(s) capacity to provide care.

Physician Name _____

Physician Signature _____

Date _____