Dane County Department of Human Services
Division of Prevention & Early Intervention

Dane County Executive - Joe Parisi

Director – Shawn Tessmann
Division Administrator – Connie Bettin, LCSW

1202 Northport Drive, Madison, WI
53704-2092 PHONE: (608) 242-6200

FOSTER CARE MEDICAL CERTIFICATION FOR EACH APPLICANT

(To be completed by a physician and returned to the address above)

Name of Patient: (Print) _____

Patient's Date of Birth: _____

The above-named adult has applied to become licensed as a foster parent with our agency. One prerequisite to being licensed is that a qualified physician certify that **a physical examination of the person has been completed within the previous six months** and that the applicant is essentially free from 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, PLEASE CHECK ONLY THOSE CONDITIONS WHICH EXIST:

☐ Cancer	☐ Seizures	☐ Alcoholism/Other Drug Dependency
☐ Heart Disease	☐ High Blood Pressure	
☐ Diabetes	☐ Ulcers	☐ Sexually Transmitted Diseases
☐ Autoimmune Deficiency	☐ Mental Health Issues	
☐ Tobacco Use	☐ HIV/AIDS	☐ Other

If you checked "other", please explain or attach a letter if there are conditions that limit their ability to provide appropriate care to foster children.

On the basis of your examination and professional judgement, is this person's condition adequate and safe for the care of foster children?

☐ Yes ☐ No

(over)

Please explain if there are any health, emotional or family conditions which limit this person's ability to provide good care for foster children.

Attach a list of prescribed medications.

Are immunizations up to date? ☐ Yes ☐ No

PHYSICIAN, PLEASE CHECK ONE:

Is a TB test indicated? ☐ Yes ☐ No

PPD Mantoux ☐

Results: Positive ☐
Negative ☐

X-ray was taken ☐

Results: Positive ☐
Negative ☐

Please contact the Dane County Foster Care Unit at (608) 242-6327 with any questions about this form. Thank you in advance for your assistance.

_____
Type/Print Name of Physician

_____
Signature of Physician

_____
Date of Examination

_____
Date of Signature