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 HOUSEHOLD MEMBER

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

Name of Patient: (Print) _____

Patient's Date of Birth _____

The above-named person is a member of a household that wishes to be licensed for child foster care. One prerequisite to being licensed is that a qualified **physician certify that a physical examination of this person has been completed within the previous 12 months** and that this household member is essentially free from any illness or disability that is likely to threaten the health of foster children or interfere with the ability of the foster parent(s) to provide good care to foster children.

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 would interfere with their parent(s) ability to provide appropriate care to foster children.

On the basis of your examination and professional judgement, is this person healthy enough to be a member of a foster family household?

☐ Yes ☐ No

(over)

Please explain on the back of this form if there are any health, emotional or family conditions which limit this household's ability to provide good care for 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 ☐ X-ray was taken ☐

Results: Positive ☐ Results: Positive ☐
Negative ☐ 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