Medical Reference For Foster Applicant

R501-12-3(7) requires each applicant to authorize a licensed healthcare professional to complete a physical exam (within the past 12 months) and send a signed Medical Reference Report directly to the Office of Licensing.
Medical Reference Reports must assess the ability of the individual to be a foster parent. ***A separate form is required for each applicant.***

TO BE COMPLETED BY APPLICANT

I,_____, give consent to have the following medical information released to the Department of Health and Human Services, Office of Licensing. It will be used for the purpose of assessing my medical eligibility to care for children in foster care who may be medically fragile or have a history of abuse, neglect or trauma.

Medical Professional Name _____Medical Professional Phone Number_____

Medical Professional Address _____

Applicant's Printed Name _____ Applicant's Signature _____

TO BE COMPLETED BY MEDICAL PROFESSIONAL

Per R501-12-3(7), this document is to be completed by a licensed health care professional and sent directly to the Agency listed above. In order to make the best possible evaluation of each foster care or adoptive applicant, receiving complete and detailed information in regard to the following is appreciated: (please feel free to use additional pages, if necessary):

1. Describe health of applicant (present and significant past).

   Physical: _____

   Emotional: _____

2. Is this individual currently under treatment? [ ] Yes [ ] No

   Is this individual Immunocompromised? [ ] Yes [ ] No

   Condition(s): _____

   Prognosis/Recommendations:
   _____

3. Is this individual currently taking any medication(s)? [ ] Yes [ ] No

   If yes, for what condition(s)? _____

   Please list medication(s) name(s): _____

   How long has the applicant been taking this/these medication(s)? _____

   How long do you anticipate this/these medication(s) will be needed? _____

4. Describe any strengths or limitations that could impact the applicant's ability to take on additional long or short-term parenting

   responsibilities: _____

5. Can you verify this individual's compliance with Utah D.O.H. recommended immunization schedule (attach report)? [ ] Yes [ ] No

6. Based upon your assessment of the person's physical and/or emotional health, would they be able to adequately provide:

   Foster Care [ ] Yes [ ] No
   (please mark one, do not skip or put n/a)

   Adoption [ ] Yes [ ] No
   (please mark one, do not skip or put n/a)

Comments:
_____

Would you like the licensor to call you? [ ] Yes [ ] No Phone Number: _____

Medical Professional's Signature: _____ Licensure/Title: _____ Date: _____

To Medical Professional: Thank you for completing this form. Please do not return it to the applicant, but return to:

DHHS Office of Licensing, 195 N 1950 W, Salt Lake City, UT 84116
Phone: 801-538-4242 Fax: 801-538-4669 Email: licenseapps@utah.gov

Utah Department of Health & Human Services

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