



TURNING POINT FAMILY CARE
PO BOX 789, WASHINGTON, UT. 84780
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Medical Report of Foster Care Applicant

Program Turning Point Family Care Attention Sarah Pewtress
Address 115 N 300 W #B200, Washington, UT 84770 Phone 674-7421

TO BE FILLED IN BY APPLICANT

I, _____ (please print name), hereby give consent to have the following medical information released to the above program.

Physician Name _____
Address _____ Phone _____

Applicant's Signature _____ Date _____
Address _____ Phone _____

TO BE COMPLETED BY PHYSICIAN

In order to make the best possible evaluation of each foster care applicant, this program will appreciate receiving the information indicated below:

1. Describe health of applicant (*present and significant past*).
Physical: _____
Emotional: _____
2. Is this individual currently under treatment Yes ___ No ___
Condition: _____
Prognosis: _____
3. Is this individual currently taking any medication which would affect his/her ability to care for adults of children?
Yes _____ No _____
4. From a medical viewpoint and from your knowledge of this person, would you recommend this person to provide care? Yes _____ No _____
5. Additional comments: _____

Physician's signature _____ Date _____