Connecticut Department of Children and Families PHYSICIAN'S STATEMENT FOR FOSTER CARE APPLICATION

DCF-020 6/17 (Rev.)



If additional writing space is needed, please write on back of form or attach an additional sheet. **AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION** I hereby authorize , M.D., to release to the Department of Children and Families The information requested below regarding myself as required by DCF regulations for foster care license applicants and their household members. DOB: Applicant's Name: Date of Last Examination: Address: (No. and Street): City: State: Zip: Applicant's Signature: Date: Has this person had any significant medical conditions (chronic or recent, including hospitalizations)? ■ No If yes, describe: ■ No If yes, describe: Is this person prescribed any medications?

Yes ■ No If yes, describe below or attach a list. Name of Medication Dosage Reason for Prescription

Please give your impression of this person's health status, both physical and emotional, and general prognosis for continued well-being. If this person is a child, is the child up to date with immunizations?							
In this person free from communicable disease?	□ No. If no.	alagaa aamma	ont.				
Is this person free from communicable disease?	☐ No. If no,	olease comme	ent:				
Do you consider this person's physical and emotional condition satisfactory to provide foster care or to adopt a child? Yes No. If no, please comment:							
SIGNATURE Name of Physician: Physician's Signature: Date:							
Name of Physician:	Physicians	s Signature:				Date:	
Address: (No. and Street):		City:		State:		Zip:	
Office Phone #:		E-mail:					
Onice i Hone #.							
SEND COMPLETED FORM TO:							
Fax or mail copies to: Department of Children and Families FA	SU		Fax #:				
Address:							
Address 2:				ı			
City State Zip							
Attention:							