KIDS CENTRAL, INC.
A COMMUNITY APPROACH TO THE WELFARE OF CHILDREN
Building Better Lives

HEALTH CERTIFICATE

NAME _____

ADDRESS _____

DATE OF BIRTH _____

The above-named individual has applied for licensure as a foster parent. The information you provide will help us in considering this application. Feel free to make additional comments.

1) How long has the patient been under your care? _____

2) General health and physical condition of your patient. _____

_____

3) Does your patient have any history or evidence of an organic or a functional disorder? _____

_____

Diagnosis _____
Prognosis _____
Current Medication(s) _____
_____

4) How would you evaluate this person's emotional stability? _____

5) Has your patient had chest X-rays within the past year? If yes, what were the results? _____

_____

6) Is your patient free from contagious or communicable disease? _____

7) Is this person physically capable of providing care to children? _____

8) Additional comments _____

_____ _____
Physician's Signature Date

_____
Physician's Printed Name