FOSTER GRANDPARENT PROGRAM
Sponsored by UNITED PLANNING ORGANIZATION
1649 Good Hope Road, SE / Washington, DC 20020-4705
(202) 610-5850 / FAX (202) 610-5902

ANNUAL HEALTH CERTIFICATION FORM rev 8/15

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone #: (___)__________ **Cell # :** (___)__________ **Last 4 digits SSN#:** ________

Sex: _____ **Age:** _____ **Birthdate:** __________

To be filled out by the Physician

If normal place a (+)		*If abnormal place a (0)*	
______	Blood Pressure	______	Chest
______	Nutrition	______	Heart
______	Eyes	______	Abdomen
______	Ears	______	Genitalia
______	Nose	______	Hernia
______	Mouth	______	Nodes
______	Urinalysis	______	VDRL

1. Has the patient ever had any major surgery? Yes___ No___
   If so what kind and when: ______________________________

   ____

   ____

2. Is the patient on any kind of medication(s)? Yes___ No___
   If yes, what kind and under what conditions: ______________________________

   ____

   ____

3. Are there any physical activities in which this patient should not engage? Yes___ No___
   If yes, explain ______________________________

   ____

   ____

PLEASE COMPLETE FRONT AND BACK OF FORM

4. **Tuberculosis** Screening – **REQUIRED TO SERVE WITH CHILDREN**

Date of Blood Test: ____________________ *(required annually – QFT–GIT, T–Spot)*

Date of Chest X-ray: ____________________ *(expires after 2 years)*

Date of Skin Test: ____________________ *(required annually)*

Test Results: ______ Normal ____ Abnormal Testing Facility Telephone: ____________________

Testing Facility: ____

5. **Has the patient had the listed childhood diseases** *(Y=Yes, N=No or D=Doesn't Remember)*:

____Chicken Pox ____Measles ____Mumps

PHYSICIAN CERTIFICATION

6. I certify that I examined the patient listed above on ____________________ and found him/her to be:

A. ______ Free of all communicable disease and able to work with children

B. ______ Free of all communicable disease and able to work with children with limitations:

a. __	*Limited/restricted mobility*	*Describe:*
b. __	*Vision impairment*	*Describe:*
c. __	*Hearing impairment*	*Describe:*
d. __	*Restricted physical activity*	*Describe:*

C. ______ Free of all communicable disease, but unable to work with children

D. ______ Not free of communicable disease and unable to work with children

7. This physical exam is valued at $100 or more. ____Yes ____No

8. Additional Comments: ____

PHYSICIAN CERTIFICATION - REQUIRED

Signature of examining Physician: ____________________ **Date:** ________

Printed name of examining Physician: ____________________

Street Address: ____________________

City, State, Zip: ____________________

Telephone: ____________________ **Fax:** ____________________

GRANDPARENT CERTIFICATION - REQUIRED

9. FGP Signature: ____________________ **Date:** ________

FGP Staff Reviewer *(print name)*: ____________________ **Date:** ________

Entered into Voltrax on ________

by (Initials) ________

____

FGP Staff Reviewer Signature