Foster Parent Applicant Medical Examination

To Be Completed By Medical Practitioner (Nurse/Physician)

Dear Medical Practitioner:

- The subject of this examination is applying to become a Foster Parent. Your report will assist in the assessment of the applicant to take on this responsibility.
- Consent To Release Of Information form can be found on the last page of this document. It is to be signed by the applicant and a copy to be retained in your records.
- If you have known the applicant for less than two years, it is necessary to review the applicant's previous health records prior to completing this form.

LAST NAME: _____ FIRST NAME: _____ D.O.B.: _____
CURRENT ADDRESS: _____
COMMUNITY OF ORIGIN:_____

Has this individual been diagnosed (currently or in the past) with any of the following communicable diseases:

- ☐ HIV / AIDS
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis

Please elaborate:

Have any individuals currently residing in the applicant's home been diagnosed with the above-mentioned communicable diseases? ☐ YES ☐ NO

Does this individual have any chronic disease that you are aware of? ☐ YES ☐ NO
If yes, please describe:

Please list all prescribed medications this individual uses:

Does this individual smoke cigarettes:

☐ YES ☐ NO

Does this individual smoke inside his/her home or allow others to smoke inside the home?

☐ YES ☐ NO

Has this person had any hospital admissions that you are aware of? ☐ YES ☐ NO

If yes, please briefly describe the reason for admission and the outcome.

Has this individual had any admission(s) to a Treatment Centre (that you are aware of) for drug/alcohol abuse, mental illness or suicidal/homicidal ideation? ☐ YES ☐ NO

If yes, please describe reason for admission(s), date of admission(s), and whether or not, in your professional opinion, these issues continue to be a risk factor for the individual:

Does this individual consume wine / spirits / beer or any other home-made alcoholic drinks? ☐ YES ☐ NO

If yes, how many times per week does the individual consume alcohol? What quantity each time?

Has this individual ever sought medical treatment for an injury that resulted from a domestic violence incident?

☐ YES ☐ NO

If yes, please comment on the nature / severity of the injury, and whether or not, in your professional opinion, risk of future domestic violence incidents still exist:

Signature of Medical Practitioner: _____

Date of Examination: _____

Address / name of Health Centre_____

Foster Parent Applicant Medical Self-Declaration

To the best of my knowledge, the medical information I have provided to the Medical Practitioner today is true and accurate. I understand that any significant changes in my own health, or the health of other individuals residing in my home must immediately be reported to the Community Social Services Worker for the purpose of reviewing my eligibility as a Foster Parent.

I further understand that if it is determined that I provided misinformation / inaccurate information to the Medical Practitioner for the purpose of completing this form, the Department of Health & Social Services maintains the right to terminate the use of my home as a Foster Placement.

Primary Applicant Signature:_____

Secondary Applicant Signature: _____

C.S.S.W. / Supervisor Signature: _____

Release/Receipt of Information

consent to **obtain/provide** information from/to other sources

I,_____of _____, Nunavut
(please print full name) (community)

_____
(address)

hereby consent to _____(name of agency/department)

	☐ **Receiving**		☐ **Releasing**

the following information:_____
(name specific information wanted)

found in the files of _____born _____
(name of person) (yyyy/mm/dd)

to the_____, the _____Office.
(Name of Board/Organization) (Name of community)

_____ _____
(If other than the client, state relationship to the client)

(Signature) (Witness)

Dated this_____day of_____, 20____.