CERTIFICATE OF HEALTH ASSESSMENT FOR FOSTER CARE PROVIDERS' OWN CHILDREN

Complete this section of the form for each child under age 16 residing in the foster home, excluding foster children.

Child's Name ___________________________ Date of Birth ___________________ Sex _______

Parent(s) Name(s) ___________________________

Address ________________________________________________________________

Street __________ City ______ Zip Code ___________

Please give dates for ALL immunization series completed by your child in the space below. Record MM/DD/YY. Update this for each time immunizations are given.

<table>
<thead>
<tr>
<th>Immunization Series</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>DPT, DT*, TD (*DT only if child is allergic to DTP)</td>
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<tr>
<td>POLIO</td>
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<td>MMR</td>
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<tr>
<td>RUBEOLA (MEASLES)</td>
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<td>MUMPS</td>
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<td>RUBELLA (GERMAN MEASLE)</td>
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<td>HIB (Hemophilus Infl. B)</td>
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<td>HBV (Hepatitis B Vaccine)</td>
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<td>VAR (Varicella-Chicken Pox)</td>
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</table>

The section is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES ___________________________

CURRENT MEDICATIONS ___________________________

NUTRITIONAL STATUS ________________

HEIGHT ___________________________ WEIGHT ___________________________

PHYSICAL EXAMINATION

HEAD ___________________________ ABDOMEN ___________________________

EENT ___________________________ GU ___________________________

TEETH ___________________________ GYN ___________________________

HEART ___________________________ SKELETAL ___________________________

LUNGS ___________________________ NEUROLOGICAL ___________________________

SCREENING TESTS (DATES DONE AND RESULTS/DO AS NEEDED)

VISION ___________________________ TBC TEST ___________________________

HEARING ___________________________ SICKLE CELL ___________________________

SPEECH ___________________________ HGB ___________________________

DDST ___________________________ UA ___________________________

OTHER ___________________________

DIAGNOSIS: ___________________________

RECOMMENDATIONS ___________________________

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION? YES _______ NO _______

DOES THIS CHILD HAVE ANY BEHAVIORAL OR HEALTH PROBLEMS WHICH WOULD PRECLUDE A FOSTER CHILD FROM BEING SAFELY PLACED IN THIS HOME? YES _______ NO _______