

**TRY-AGAIN HOMES INCORPORATED
WEST VIRGINIA SPECIALIZED FOSTER CARE
MEDICAL REPORT ON FOSTER PARENTS**

This examination is required to determine whether the health of an applicant and his family will permit him to board a child. Current health as well as prognosis for the future should be considered. This medical information is for the use of Try-Again Homes, Inc. only.

**HEALTH HISTORY
TO BE COMPLETED BY APPLICANT**

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

Have you had or do you now have any of the following:

Fainting Spells _____ Convulsive Seizures _____

Allergies _____ Hepatitis _____

Anemia _____ Rheumatic Fever _____

Diabetes _____ Tuberculosis _____

Other disease affecting the lungs or heart? (specify) _____

Diseases or disorders of the nervous system? (specify) _____

Give history of hospitalization _____

Do you have or have you had any medical problems which would limit the number and kind of children which you could accept for care? _____

Signed _____ Date Signed _____

PHYSICIAN'S MEDICAL REPORT

Do you have any comments on patient's health history as reported by him/her above?

(Use reverse side for comments)

Is patient currently under medical treatment that would make it unwise for a foster child to be placed in his/her home? _____

Weight _____ Blood Pressure _____
Height _____ Lungs _____
Heart _____ Chest X-Ray _____ Date Taken _____

MEDICAL REPORT ON FOSTER PARENT

General Vitality Level High _____ Low _____

Nervous Condition _____

Communicable Diseases _____

Recommended laboratory tests and x-rays, including Serology if indicated:

Test Results _____ Date _____

Prognosis for continued health _____

How long have you known this patient? _____

If you are aware of any physical, mental and emotional problems, past or present, which should be given consideration in Try-Again Homes, Inc. use of the patient's home for care of foster children, please comment:

Date of Examination _____

Physician's Signature _____