MEDICAL EVALUATION
NORTH CAROLINA DIVISION OF SOCIAL SERVICES

_____

(Name of Agency Requesting Information)

This individual has come to you in response to a request from this agency for a report on his/her medical condition. It is important for us to know of any medical factors that may interfere with this individual's care for or interaction with a foster child. The individual named below understands that this information will be provided to the NC Division of Social Services.

Name (Last) (First) (Middle)	Gender ☐Male ☐Female	Date of Birth
Weight:	Height:	Blood Pressure:

MEDICAL CONDITIONS

Chronic/Ongoing Medical Conditions ☐Yes ☐No If yes, explain:

A tuberculin skin test should be administered if any of the following conditions exist:

☐Yes ☐No Born in or lived for more than a month in Africa, Asia, Central America, S. America, E. Europe.
☐Yes ☐No Immunocompromised due to a medical condition or from taking an immunosuppressive drug.
☐Yes ☐No High risk behavior, such as, using crack cocaine or IV drugs, or living or working in a high risk area, such as, jail or prison, homeless shelter, or a health care worker with direct contact with patients.
☐Yes ☐No Exposed to a person with infectious tuberculosis.
☐Yes ☐No Currently having symptoms of tuberculosis, such as, unexplained productive cough or a fever lasting more than 3 weeks, night sweats, shortness of breath, chest pain, unexplained weight loss or fatigue.
☐Yes ☐No Based on above assessment a TB Skin Test/Chest X-Ray is needed.
If Yes, date of TB Skin Test/Chest X-Ray: _____ Results: _____

Communicable Diseases ☐Yes ☐No If yes, explain:

Limitations to Physical Activity ☐Yes ☐No If yes, explain:

Behavioral Health Issues/Mental Health Diagnosis ☐Yes ☐No If yes, explain:

I have examined the above named individual and reviewed his/her medical history. It is my opinion that he/she is medically cleared to serve as a foster parent or reside as a household member in a home where foster children are present. ☐Yes ☐No

Physician's, Physician Assistant's, Nurse Practitioner's Signature:_____

Print Name of Physician, PA or NP (circle applicable title):_____

Address:_____

Phone #:_____ Date:_____