ARIZONA DEPARTMENT OF CHILD SAFETY
Office of Licensing and Regulation

PHYSICIAN'S STATEMENT

The purpose of the **Physician's Statement** is to determine whether the patient is physically, emotionally, and mentally able to provide care for a foster/adoptive child. Responsibilities may include 24-hour supervision, personal care, transportation, positive behavior management, providing follow-up care and medical treatment, and administering medication.

PATIENT'S NAME *(Last, First, M.I.)*	LENGTH OF TIME IN YOUR CARE

Current status of patient's general physical health

Current status of general emotional health, if known

List of prescribed and over-the-counter medications	Prescribing physician

Would any of the over-the-counter or prescription medications regularly used by the patient interfere with the safe care and supervision of children (e.g., drowsiness, disorientation, lack of concentration, etc.) ☐ Yes ☐ No If yes, explain.

Have you reviewed the Health Self Disclosure form (CSO-1232A)? ☐ Yes ☐ No If yes, explain.

Does this patient have a medical, emotional, or other condition that could interfere with the ability to care for, nurture, or supervise children (e.g., restrictions on lifting, lack of strength or stamina, unusual stressors, communicable disease, etc.)? ☐ Yes ☐ No

If yes, explain and provide your recommendations to limit risk to the health or well-being of either the patient or children placed in the home.

Does the patient present with or is known to have communicable diseases? ☐ Yes ☐ No ☐ Unknown

If Unknown: Is the patient presenting with any symptoms that could indicate a communicable disease? ☐ Yes ☐ No

If Yes, explain below.

PHYSICIAN'S NAME *(Please Print)*	LICENSE NO.

ADDRESS *(No., Street, City, State, ZIP)*

PHYSICIAN'S SIGNATURE	DATE

Please send this completed Physician's Statement to the agency specified below. If you have any questions regarding this form, the purpose of the exam, or if you wish to add to your comments, please contact the agency below.

AGENCY SPECIALIST'S NAME	AGENCY NAME	PHONE NO.

AGENCY ADDRESS *(No., Street, City, State, ZIP)*

See page 2 for EOE/ADA/GINA disclosure

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