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Kansas Department for Children and Families
Foster Care Licensing and Background Checks Division
PO BOX 1424 ● Topeka, KS 66601-1424
500 SW Van Buren St ● 2nd Floor ● Topeka, KS 66603
Fax: (785) 296-8609
Website: http://www.dcf.ks.gov

CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this DCF form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

_____ _____
Name of the facility (exactly as stated on the license) License #

_____
Street Address City Zip Code County

Check type of child care facility:

☐ Attendant Care Facility ☐ Group Boarding Home ☐ Secure Residential Treatment Facility
☐ Detention Center ☐ Staff Secure Facility ☐ Secure Care Center
☐ Family Foster Home ☐ Residential Center ☐ Juvenile Crisis Intervention Center

Name of Foster Parent/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.	Yes	No
1. Do you see a physician regularly for any health condition?	☐	☐
2. Are you taking any medication regularly?	☐	☐
3. Have you had any surgery in the past 3 years?	☐	☐
4. Do you have any handicapping conditions which might interfere with the care of children?	☐	☐
5. Do you have any chronic illness conditions such as:		

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Cancer	☐	☐	Alcoholism	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Convulsions	☐	☐	Liver Disease	☐	☐
Lung Disease	☐	☐	Mental Illness	☐	☐	Other	☐	☐

If Other, Describe: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

Record results of TB test or attach results to this form.

Negative tuberculin test ☐ or negative chest x-ray ☐ on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____ _____
Licensed Physician/Nurse Signature or Health Department **Date (MM/DD/YYYY)**