Reset

SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES

PHYSICAL EXAMINATION BLANK FOR
FOSTER PARENT

APPLICANT'S NAME & ADDRESS:

HISTORY OF COMMUNICABLE DISEASE IN HOUSEHOLD:

DATE OF CHEST X-RAY OR PPD SKIN TEST:

BLOOD PRESSURE:

SPECIAL PHYSICAL FINDINGS NOTED; INDICATING PRESENCE OF DISABLING DEFECTS OR COMMUNICABLE DISEASE:

BLOOD TEST FOR SYPHILIS?
☐ YES ☐ NO

IF YES, GIVE DATE:

LABORATORY FINDINGS,
IF INDICATED:

THIS IS TO CERTIFY THAT I HAVE MADE A PHYSICAL EXAMINATION OF THIS APPLICANT ON ..... SUFFICIENT TO DETERMINE THE PRESENCE OR ABSENCE OF THE DISEASE STATES MENTIONED ABOVE. IN MY OPINION THE PHYSICAL AND MENTAL HEALTH OF THIS APPLICANT IS SUCH THAT IT WILL NOT ADVERSELY AFFECT THE CARE OF FOSTER CHILDREN EXCEPT AS MAY BE HEREIN INDICATED.

RECOMMENDATION:

SIGNATURE:

DATE: