

## Medical Report for Foster Care

Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone #: \_\_\_\_\_

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**(To be completed by physician)**

**This patient has come to you in response to a request from LoneStar Solutions for a complete report of the patient's physical condition. It is important for us to know of any health factors which might interfere with their ability to *operate a vehicle* or individually parent one or more *active* foster children for extended periods of time.**

Current medical concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**It is my opinion that this person is physically and emotionally capable of operating a vehicle, providing individual foster care to one or more active children for extended period of times. It is also my opinion that this person is physically and emotionally capable of implementing physical restraints on children who are a danger to themselves, others, or their environment, and performing CPR for an undetermined amount of time as the situation would require (these procedures are often performed on the ground with physical exertion):**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Baseline TB Test:**

TB Test Given: \_\_\_\_\_ Results: \_\_\_\_\_ Date Read: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**I authorize my physician to release to LoneStar Solutions the above information from my medical records:**

Foster Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return This Form To: LONESTAR SOLUTIONS (Attn: Sherri)  
PO BOX 13517, ARLINGTON, TX 76094-0517  
Pone: 817-265-2344 Fax: 817-277-5610