

Medical Report for Foster Care

Name: _____ Date of Exam: _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone #: _____

(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: _____

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
Phone: 817-265-2344 Fax: 817-277-5610