Waterford Country School Foster Care
2 Clinic Drive, Norwich, CT 06360

Physician's Statement for Foster Care Applicant

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION	
I hereby authorize _____, MD to release to the Waterford Country School the information requested below regarding myself, as required by the State of Connecticut Department of Children and Families regulations for foster care applicants and their children.	
SIGNATURE OF APPLICANT	DATE
ADDRESS NO. AND STREET	CITY, STATE, ZIP

FOSTER CARE APPLICANT'S NAME:_____

DATE OF BIRTH: _____

DATE OF LAST EXAMINATION: _____

How long have you known the applicant? _____

Has the applicant had any significant chronic or active medical, familial or psychiatric conditions? ☐ Yes ☐ No If any, describe:

_____
_____
_____
_____

Has the applicant had any significant hospital admissions? ☐Yes ☐ No
If yes, list with dates, diagnoses, treatment and results:

_____
_____
_____
_____

Please give your impression of the applicant's health status, both physical and emotional; general prognosis for continued well being:

_____
_____
_____
_____

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Do you consider the applicant's physical and emotional condition satisfactory to provide foster care? ☐ Yes ☐ No
If no, please comment:

_____
_____
_____
_____

Is the applicant free from communicable disease? ☐ Yes ☐ No
If no, please comment:

_____
_____
_____
_____

PRINT NAME OF PHYSICIAN: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

SIGNATURE OF PHYSICIAN: _____

DATE: _____

NOTE: This report should be mailed directly by the examining physician to:

Waterford Country School Foster Care Program
ATTN: Licensing Unit
2 Clinic Drive
Norwich, CT 06360