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

Physician's Statement for Child of Foster Care Applicant

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION	
I hereby authorize _____, MD to release to the Waterford Country School the information requested below regarding my minor children, 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

CHILD'S NAME:_____

DATE OF BIRTH: _____

DATE OF LAST EXAMINATION: _____

How long have you known the child? _____

Is the child up to date with immunizations and well child checks? □ Yes □ No

_____

_____

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

_____

_____

_____

_____

Is there any reason that the child's physical and/or emotional condition may interfere with the placement of foster children within his/her home? □ Yes □ No
If yes, please comment:

_____

_____

_____

_____

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Is the child free from communicable diseases? □ Yes □ No

_____
_____
_____
_____

Any other comments?

_____
_____
_____
_____

PRINT NAME OF PHYSICIAN: _____

ADDRESS: _____

_____

TELEPONE NUMBER: _____

SIGNATURE OF PHYSICIAN: _____

DATE: _____

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

Waterford Country School Foster Care Program
Attn: Foster Care Secretary
2 Clinic Drive
Norwich, CT 06360