



Resource Family Approval (RFA)

Health Screening for County/Agency: _____

Purpose of Form: To verify applicant's physical health. Must be completed by a licensed health professional.

Applicant Name: (first, middle, last)	Date of Birth:
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Please provide listing of current licensed health professionals (Name, Address, and Telephone Number)

Physician: _____

Specialist: _____

Other: _____

Release of Information: I hereby authorize _____ to release the medical information contained on
(Doctor's name)
this form, to the _____ for the purposes of determining my physical health.
(County/Agency)

Patient Signature	Date
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I. Medical History: (check any that apply and provide comment):

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Impaired Sight	<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heredity Conditions	<input type="checkbox"/> Chronic Medical Conditions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Impaired Hearing	<input type="checkbox"/> Allergies	<input type="checkbox"/> Respiratory Condition
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> TB screen <input type="checkbox"/> test <input type="checkbox"/> neg <input type="checkbox"/> positive <input type="checkbox"/> xray	
<input type="checkbox"/> Other-		

Comment: _____

Tobacco Usage

Do you smoke nicotine cigarettes? _____ If so, how many packs per day? _____

Alcohol Consumption

How many alcoholic beverages do you consume daily? _____

Limits or restrictions on physical activity: _____

II. Physical Examination:

Height: _____ Weight: _____ Blood Pressure: _____

Comments and Diagnoses

III. Medications

(Please list all medications the patient is currently taking including medical marijuana.
Additional medications can be listed in an attachment.)

Name of Medication	Dose and Condition Prescribed For:

IV. Additional Comments by Licensed Health Professional

(Please note any health condition that may create a risk to the health or safety of the patient, children, or others in the patient's care)

V. Certification

I certify that I completed the health screening on this patient for the purpose of verifying the patient's physical health.

Date Examined	Signature of Licensed Health Professional
Telephone Number	Printed Name of Licensed Health Professional
Address of Licensed Health Professional	

Reminder to Applicant: Please return the completed RFA Health Screening to your assigned RF worker.