NORTHERN CALIFORNIA FAMILY CENTER
APPLICANT'S OWN REPORT ON HEALTH

TO: ___ FOSTER CARE LICENSING ___ ADOPTIONS ____ DAY CARE

NAME____DATE_______________

Address____

Height_______ Weight______Age________ Dates of last medical examination_______________. General Health Fair_____ Good______

Sleep Fair_____ Good______

Tire easily Yes______ No________

Headaches Often_______

Occasionally________

Doctor_____________________________________

Address____Phone___________

What do you consider to be your most serious health problem?_____

____

HAVE YOU EVER HAD TREATMENT FOR:

	NO	YES
Diabetes	___	___
Tuberculosis	___	___
Heart Condition	___	___
Arthritis	___	___
Ulcers	___	___
Epilepsy	___	___
Cancer	___	___
Allergies, Drugs and/or Alcohol dependency problems	___	___

HAVE YOU EVER BEEN HOSPITALIZED FOR A NERVOUS BREAKDOWN?______

Are you taking medicine with any frequency?(If yes, name of drug, dosage, and reason)______

____

____

HAVE YOU HAD:

		YES	NO
1.	Surgery	___	___
2.	Physical handicap	___	___
3.	Psychiatric treatment	___	___
4.	Disability pension	___	___

IF YOU CHECKED "YES" FOR ANY OF THE ABOVE PLEASE EXPLAIN__________

____

____

____

Family Doctor's name and address_____________________________________

____

Parents Doctor's name and address____________________________________

____

Parent's Doctor's name and address___________________________________

____

Date and place ___________ _________ CA Serial Number_________

I CERTIFY UNDER PENALTY F PERJURY THAT THE FORGOING IS TRUE AND CORRECT.

____

Signature

Signed at_____________________________________on__________________

city state date

THESE FORMS ARE <u>NOT</u> TO BE SENT TO YOUR PHYSICIAN. Each parent must fill out a separate form and return to the agency.