CSO-1269A
(07/22)

ARIZONA DEPARTMENT OF CHILD SAFETY

PHYSICIAN'S STATEMENT

Office of Licensing and Regulation

The purpose of the Physician's Statement is to determine whether the patient is physically, emotionally, and mentally able to provide care for a foster/adoptive child. Responsibilities may include 24-hour supervision, personal care, transportation, positive behavior management, providing follow-up care and medical treatment, and administering medication.

Patient's Information

Prospective Caregiver Parent(s) Name (Last, First) | *Length of Time in Your Care*

Current status of patient's general physical health

Current status of general emotional health, if known

List of prescribed and over-the-counter medications	Prescribing physician

Would any of the over-the-counter or prescription medications regularly used by the patient interfere with the safe care and supervision of children (e.g., drowsiness, disorientation, lack of concentration, etc.) ☐ Yes ☐ No

If yes, explain and provide your recommendations to limit risk to the health or well-being of either the patient or children placed in the home.

Have you reviewed the Health Self Disclosure form (CSO-1232A)? ☐ Yes ☐ No

If yes, explain.

CSO-1269A
(07/22)

ARIZONA DEPARTMENT OF CHILD SAFETY

PHYSICIAN'S STATEMENT

Office of Licensing and Regulation

Does this patient have a medical, emotional, or other condition that could interfere with the ability to care for, nurture, or supervise children (e.g., restrictions on lifting, lack of strength or stamina, unusual stressors, communicable disease, etc.)? ☐ Yes ☐ No

If yes, explain and provide your recommendations to limit risk to the health or well-being of either the patient or children placed in the home.

Does the patient present with or is known to have communicable diseases? ☐ Yes ☐ No ☐ Unknown

If Unknown: Is the patient presenting with any symptoms that could indicate a communicable disease? ☐ Yes ☐ No

If Yes, explain below

Physician Information

Per R21-6-101(47), "Medical professional" means a doctor of medicine or osteopathy, physician's assistant, or registered nurse practitioner licensed in A.R.S. Title 32, or a doctor of medicine licensed and authorized to practice in another state or foreign country. A medical professional from another state or foreign country must provide verification of valid and current licensure in that state or country. Per R21-6-101(55): "Physician's Statement" means information on the physical, emotional, and mental health of any adult household member, providing care for a foster child, using a form approved by OLR. The statement shall be based on an examination by a medical professional.

Physician's Name (Please Print) | *License No.*

Address (No., Street) | *City* | *State* | *Zip*

Physician's Signature | *Date*

Please send this completed Physician's Statement to the agency specified below.

If you have any questions regarding this form, the purpose of the exam, or if you wish to add to your comments, please contact the agency below.

Agency Specialist's Name | *Agency Name* | *Phone No*

Address (No., Street) | *City* | *State* | *Zip*

DEPARTMENT OF CHILD SAFETY
STATE OF ARIZONA