

# WhimSpire, Inc.

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*Administrative Office  
309 South Cascade Ave.  
Montrose, CO 81401  
Phone: (970) 252-0030  
Fax: (866) 963-1629*

## HEALTH APPRAISAL

Instructions: Arrange for your health care provider to complete this form and either return the form to you or mail it directly to WhimSpire.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

WhimSpire is a licensed child placement agency and is required by Colorado Department of Human Services Rules to have a health certification for all foster parents and all persons living in the homes of foster parents. This appraisal is requested to assist WhimSpire in determining the suitability of the person to care for children and youth. The person named above:

- Is a foster parent or applicant for a foster parent contract.
- Lives in the home of a foster parent or applicant for a foster parent contract.

I authorize the release of this requested health information to WhimSpire.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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The following information is to be provided by a licensed health care provider:

1. Date of this health examination (or last health exam if done in the last six months):  
  
\_\_\_\_\_
2. Does this person suffer from any illness or communicable disease that would adversely affect children in care? If yes, please provide details at #7.
3. Does this person have an emotional or psychological condition that is likely to be aggravated by care of children or placement of additional children in her/his home? If yes, please provide details at #7.

**QUESTIONS 4, 5, AND 6 ARE TO BE COMPLETED FOR PERSONS 18 AND OVER.**

4. Does this person have any disease or physical impairment that might limit ability to care for children? If yes, please provide details at #7.
5. Does this person have an emotional or psychological condition that would impair ability to care for children? If yes, please provide details at #7.
6. To the best of your knowledge, does this person misuse any chemicals including prescription drugs, nonprescription drugs, illegal drugs, or alcohol? If yes, please provide details at #7.
7. Please provide details for any yes responses to items 2, 3, 4, 5, or 6.

8. Unless otherwise indicated here, the next health evaluation will be required in three years:

\_\_\_\_\_

Alternate Date

9. Doctor's printed name: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_

Doctor's address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_