

**CARING for Children, Inc.**  
 PO Box 19113  
 Asheville, North Carolina 28815  
 (828) 298-0186

**Request for Medical Information**

To issue a family foster home license, the North Carolina Department of Human Resources Division of Social Services must have medical information on each person prior to their employment as a child care provider in a residential child care facility. To obtain licensing and to protect both the facility/agency and the children who reside in the foster home or facility, CARING for Children, Inc. updates employee medical information prior to employment and annually thereafter.

I, \_\_\_\_\_, agree to the release of pertinent information by  
 \_\_\_\_\_, who is a licensed medical provider.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

**General Information**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
 Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_

**History of Illness**

	Yes	No		Yes	No
Tuberculosis or other Pulmonary defects	<input type="checkbox"/>	<input type="checkbox"/>	Fainting & Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Serious Defects of Bones and Joints	<input type="checkbox"/>	<input type="checkbox"/>
Mental or Emotional Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Other Diseases	<input type="checkbox"/>	<input type="checkbox"/>
			Specify if Yes:		

\_\_\_\_\_  
 \_\_\_\_\_

**Physical Examination** (circle all that were examined)

Heart	Lungs	Abdomen	Genitalia
ENT	Extremities	Hernia	Eyes

Date of Examination: \_\_\_\_\_  
 Date of Tuberculin Skin Test: \_\_\_\_\_ Result: \_\_\_\_\_  
 Date of Chest X-Ray:\* \_\_\_\_\_ Result: \_\_\_\_\_  
 (Required only if tuberculin test is positive)

Please comment on any physical, mental, or emotional condition apparent from your examination or any knowledge of the above-named person that might affect the health, safety, or welfare of children residing in the home or facility: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Licensed Medical Provider's Signature

\_\_\_\_\_  
 Date

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

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Request/Waiver of Vaccination for Hepatitis B

I wish to be inoculated with the Hepatitis B Vaccine as provided for by CARING for Children, Inc. I have been adequately informed about the availability, need for, and nature of the Hepatitis B Vaccination as well as of the consequences of not being immunized.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CFC Administrator

\_\_\_\_\_  
Date

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future (during my employ at CARING for Children, Inc.) I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
CFC Administrator

\_\_\_\_\_  
Date