PHYSICIAN’S STATEMENT FOR: ________________________________

PURPOSE: This statement is requested for purpose of the administration of the Foster Grandparent Program. All information will be kept strictly confidential.

DUTIES: Foster Grandparents serve between 20 – 40 hours per week helping children with special and exceptional needs.

REPORT: From the patient’s most recent medical examination and/or from your records, please indicate if the patient named above is (check one):

_____ Capable of performing the duties stated above without detriment to himself/herself and the children he/she will serve.

_____ Not capable of performing the duties stated above without detriment to himself/herself and the children he/she will serve.

PHYSICIAN’S PRINTED NAME: ____________________________________________

PHYSICIAN’S TELEPHONE NUMBER: _______________________________________

SUMMARY OF PATIENT’S GENERAL HEALTH:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

MEDICALLY NECESSARY MEDICATION:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

(PHYSICIAN’S SIGNATURE) (DATE)

YOU MAY GIVE THIS FORM BACK TO THE PATIENT OR FAX THE FORM TO 832-408-3513 ATTENTION: SARAH CLASSEN, FGP DEPT.