



**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:**

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**MEDICALLY NECESSARY MEDICATION:**

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\_\_\_\_\_  
(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.**