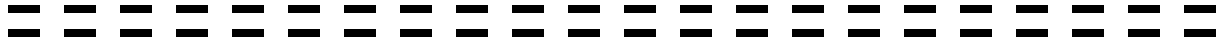


GREENLEAF TREATMENT FOSTER CARE PROGRAM



6301 Greentree Rd.
Bethesda, MD 20817
301-365-4480
301-365-2536 fax

MEDICAL HISTORY

Prospective Parent's Name: _____

Birthdate: _____

Date of Physical: _____

ILLNESSES: (place dates where applicable)

Alcoholism: _____

Hypertension: _____

Arthritis: _____

Asthma: _____

Epilepsy: _____

Heart Disease: _____

Nervous System Disease: _____

Ulcers: _____

PHYSICAL EXAMINATION:

Weight: _____

Height: _____

Skin: _____

Head: _____

Eyes: _____

Ears: _____

Teeth: _____

Tonsils: _____

Chest: _____

Heart: _____

Thyroid: _____

TB Test Date: _____

Result: _____

Has this patient ever utilized psychotherapy services? _____ When? _____

OVER

I hereby certify:

That the applicant is in sufficiently good health and that placing an emotionally/behaviorally challenged youth in this home will not jeopardize the health or safety of the youth.

YES

NO

That the placement of a youth in this home will not jeopardize the applicant's health

YES

NO

Signature of Examining Physician _____

Typed/Printed Physician's Name _____

License Number _____

Address _____

City, State and Zip Code _____

Telephone Number _____