

**SOUTH CAROLINA  
DEPARTMENT OF SOCIAL SERVICES**

**PHYSICAL EXAMINATION BLANK FOR  
FOSTER PARENT**

APPLICANT'S NAME & ADDRESS:

HISTORY OF COMMUNICABLE DISEASE IN HOUSEHOLD:

DATE OF CHEST X-RAY OR PPD SKIN  
TEST:

BLOOD PRESSURE:

SPECIAL PHYSICAL FINDINGS NOTED; INDICATING PRESENCE OF DISABLING DEFECTS OR COMMUNICABLE DISEASE:

BLOOD TEST FOR SYPHILIS?

YES

NO

IF YES, GIVE DATE:

LABORATORY FINDINGS,  
IF INDICATED:

*THIS IS TO CERTIFY THAT I HAVE MADE A PHYSICAL EXAMINATION OF THIS APPLICANT ON .....  
SUFFICIENT TO DETERMINE THE PRESENCE OR ABSENCE OF THE DISEASE STATES MENTIONED ABOVE. IN MY  
OPINION THE PHYSICAL AND MENTAL HEALTH OF THIS APPLICANT IS SUCH THAT IT WILL NOT ADVERSELY AFFECT  
THE CARE OF FOSTER CHILDREN EXCEPT AS MAY BE HEREIN INDICATED.*

RECOMMENDATION:.....

SIGNATURE:

DATE: