30 Eastern Ave • Suite 300 • Malden MA 02148 • Phone: 781-605-3724 Fax:321-445-4749

PHYSICAL EXAMINATION FORM

The following individual has applied to AG Adult Foster Care to become a caregiver for individuals at home. We are required to obtain evidence of a current physical annual examination (within 12 months)

Caregiver's Name: _____ D.O.B. : _____/_____/_____

Street: _____ City: _____ State _____ Zip: _____

Height: _____ Weight: _____ Allergies: _____

Immunizations:

TB Test date and finding: _____ Chest X-ray (if needed) _____

Last Physical Exam Date: _____

Hepatitis B Vaccine: _____ Tetanus: _____ Flu Vaccine: _____ Pneumonia Vaccine: _____

Other: _____

Specify diagnosis and treatment (Includes medical and psychiatric): _____
_____
_____
_____

List any prescribed medication (including psychiatric): _____
_____
_____

I approve _____'s participation as a care giver in the AFC Program of AG Adult Foster Care. He/she does not have any medical or psychiatric limitations and can provide care to the member in his/her home.

Physician Name: _____

Physician's Signature: _____ Date: _____