KINSHIP CARE ARRANGEMENT

STATEMENT ON THE HEALTH OF THE KINSHIP CARER

SOCIAL WORKER: ……...

Tel: ……..……..……

MEDICAL ADVISER: ……..

Tel: ……..……

KINSHIPCARER:

SURNAME: ……..…… FORENAME: ……..……..

ADDRESS……..……

……..…….. ……

……..…….. ……

DATE OF BIRTH: ……

To be completed by the Kinship Carer **:**

Do you consider yourself to be in good health? Yes / No

Are you taking any medication on a regular basis? Yes / No
If yes, please specify

Have you had any significant health issues in the past, including mental health? Yes / No
If yes, please specify

CONSENT

I understand that in accordance with the terms of Looked After children Regulation 2009 a statement prepared by a doctor is required, confirming that I have no medical problems (physical or mental) likely to adversely affect my ability to look after a child. I consent to the provision of this statement by my General Practitioner to the Local Authority (Moray Council).

My Doctor is…….. …….. Based at ……..

Signature …… Date …….

TO BE COMPLETED BY THE CARER'S GENERAL PRACTITIONER

Are you the usual attendant of the above named carer? Yes / No

If not, please explain current role.

How long have you been his/her doctor?

At what date do your records begin?

Does the applicant have any current physical or mental health conditions? Yes / No
Please comment

Has the applicant had any significant physical or mental health problems in the past? Yes / No
If Yes, please give details

Is the applicant on any current medication? Yes / No
If Yes please give details?

In addition, we would welcome your opinion:

- **As to the state of the above named carer's health with respect to his/her ability to look after a child.**

- **How the applicant has cared for their own or other people's children.**

- **Any concerns abut the safety of children in the applicant's care.**

- **The applicant's approach to health generally and to promoting a healthy lifestyle including the applicant's ability to communicate with health professionals.**

- **Any other comments**

Please let us know if you are happy for the applicant to see your comments

Yes / No

Signed ……...

Address ……..

Name (in CAPITALS) …… …….. Date …….

TO BE COMPLETED BY THE MEDICAL ADVISER TO THE LOCAL AUTHORITY

Please comment on this report for Kinship Caring

Signature …… Date…….