Queensland Government

Carer Applicant
Health & Wellbeing Questionnaire

Disclosure and Privacy Notice

The Department Child Safety, Youth and Women is collecting the personal information on this form for the purpose of assessing the carer applicant/s for consideration to become approved foster carers. The collection of this information is authorised by the *Child Protection Act 1999* and the *Child Protection Regulation 2011*. Your personal information will be treated in accordance with the *Information Privacy Act 2009.*

Under the *Children's Court Rules 2016 and the Director of Child Protection Litigation Act 2016*, the department is required to provide relevant information to the Director of Child Protection Litigation (DCPL) in relation to child protection proceedings, and the DCPL has a duty to disclose documents relevant to the proceeding to each other party. Therefore, any information provided to the department that may be relevant to current or future court proceedings may be provided to the parties, including the parents. This may include applications for future child protection orders for children already in your care as an approved foster or kinship carer, such as long-term Child Protection Orders.

Assessment details			
Given Name			
Middle Name/s			
Family Name			
Address Line 1			
Line 2			
Suburb/Town			
State/Territory		Postcode	
Date of birth (dd/mm/yyy)	/ /	Gender	

GP contact details Please supply the name and contact details of your GP (Please provide contact details of the GP who can comment on your physical and mental health).			
Name			
Address Line 1			
Line 2			
Suburb/Town			
State/Territory		Postcode	
Contact Number			

Consent for release of medical check information			
I consent to the results of my medical checks being used by the staff member/s of the fostering service, assessment panel or the appointed consultant for the purpose of assessing my application to become an approved foster carer of kinship carer.			
Signature			
Name		Date	

How would you describe your health? (tick one)			
Excellent ☐	Good ☐	Fair ☐	Poor ☐

Have you had any of the following:	**Yes**	**No**
Past or current back or shoulder injuries	☐	☐
Muscular/Skeletal problems	☐	☐
High blood pressure	☐	☐
Heart complaint	☐	☐
Rheumatic fever	☐	☐
Asthma, TB or lung disease	☐	☐
Ulcers	☐	☐
Bowel, liver or gall bladder disease	☐	☐
Cancer or tumour of any kind	☐	☐
Diabetes	☐	☐
Visual difficulties (other than glasses)	☐	☐
Hearing difficulties	☐	☐
Major surgery	☐	☐
Psychological/Psychiatric disorders	☐	☐
Anxiety/Depressive illness	☐	☐
Neurological disorder	☐	☐
Blood borne virus (HepC, HIV etc.)	☐	☐
Current infectious disease	☐	☐

If **yes** to any of the above, please provide details on page 4.

Have you	Yes	No
Had any immunisations as an adult?	☐	☐
Received a booster dose of the pertussis (whooping cough) vaccine in the past 10 years?	☐	☐
If **yes,** please provide immunisation details.		

Have you ever	Yes	No
Used illegal drugs	☐	☐
Misused medication	☐	☐
Been involved in illegal activities	☐	☐
Had a problem managing your anger	☐	☐
Gambled compulsively	☐	☐
If yes to any of the above please provide details.		

Please answer the questions below

1. Do you drink alcohol? **Yes** ☐ **No** ☐

   If yes, in what form and daily quantity? _____

2. Do you smoke? **Yes** ☐ **No** ☐

   If yes, how often do you smoke? _____

   If yes, how many years have you been smoking? _____

3. Have you been hospitalised recently? **Yes** ☐ **No** ☐

   If yes, please provide details. _____

4. Have you used medication on a regular basis? **Yes** ☐ **No** ☐

   If yes, please provide details. _____

5. Have you lodged or received a workers compensation claim? **Yes** ☐ **No** ☐

   If yes, please provide details. _____

6.	Have you had difficulty obtaining or keeping life insurance or other health insurance?	**Yes** ☐ **No** ☐
	If yes, please provide details.	
7.	Any other illness or disability?	**Yes** ☐ **No** ☐
	If yes, please provide details.	

I confirm the above information is correct

Applicant's signature:			
Name (please print):		Date:	

Details of medical conditions (*from page 2)*
Please comment on how these medical conditions may impact your ability to care for a child or young person

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Carer Applicant
Authority to release medical information

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Applicant information			
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Middle Name/s			
Family Name			
Address Line 1			
Line 2			
Suburb/Town			
State/Territory		Postcode	
Date of birth (dd/mm/yyy)	/ /	Gender	

Dear Doctor

I request that you make available to the Department of Child Safety, Youth and Women any information pertaining to my medical history, including hospital details and any information from specialist medical services.

Applicant's signature		Date	/ /