Arkansas Department of Human Services
Division of Children and Family Services

RECEIPT FOR MEDICAL PASSPORT OF A FOSTER CHILD AND ACKNOWLEDGEMENT OF CONFIDENTIAL NATURE OF INFORMATION CONTAINED IN THE MEDICAL PASSPORT

I have received the Medical Passport for _____
a child placed in my care.

I understand that all Medical Passport information is confidential. I may share it only with health care providers and Department of Human Services staff. If I have any questions, I will contact the child's foster care worker.

I will return the Medical Passport to the Department of Human Services Division of Children and Family Services.

_____ _____
Foster Care Provider's Signature Date

_____ _____
Foster Care Provider (print/type) Group Home/Institution

VERIFICATION OF MEDI-ALERT CFS-362

(If a new Medi-Alert [CFS-362] is not completed, the worker must complete this section.)

I verify that the information on the existing Medi-Alert (CFS-362) dated _____
is current and complete on the date of this placement.

_____ _____
Worker's Signature Date

RETURN OF MEDICAL PASSPORT FROM FOSTER CARE PROVIDER

The above-named child has been removed from the provider's care and the Medical Passport is returned.

_____ _____
Worker's Signature Date