Adoption

1008 South Second Street
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www.childaid.org

Adoption, Child Care, Foster Care, In-Home Services, Nurturing, Parents as Teachers, Pre-K Counts, Relatives As Parents Program, Together, Triple P, Youth Mentoring

MEDICAL RECORD

Name: ____

Address: ____

____

Date of Birth: ____

Phone Number: ____

PATIENT'S PRESENT CONDITION:

Weight ___________ Height _____________ Lungs __________ Heart__________

Blood pressure ___________________________ Ears, nose, throat ____________

Abdomen _______________ Reflexes ____________________

PATIENT'S MEDICAL HISTORY:

Asthma ______________

Allergies ______________

Cancer ______________

Epilepsy ______________

Diabetes ______________

Infectious diseases ______________

History of alcohol dependency ______________

Hearing impairment ______________

Vision impairment ______________

Ulcers ______________

Tuberculosis ______________

Serious illness ______________

History of substance abuse ______________

Regularly prescribed medications: ____

Accidents: ____

Operations: ____

Is patient free from communicable disease? ___________Yes ___________No

Any disabling disorder or other medical condition that would in any way impair his/her ability to foster/adopt a child, or to raise and care for a child?

____

How long have you known the patient? ____

Professional impression of patient’s emotional stability:

____

____

____

Professional opinion of patient’s health and capability for caring for a foster/adoptive child:

____

____

____

____

I find this patient to be in good physical health and capable of caring for an adoptive child or providing foster care.

____

Signature Date

Please print physician’s name, address, and phone number below:

AS REQUIRED BY LAW, please attach a print-out from this physical examination appointment.