Foster Care

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, 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.