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# MEDICAL REPORT FOR ADOPTIVE APPLICANT

Name of Person Examined: _____ Date: _____
(Last) (First) (Middle)

Date of Birth:_____

Please complete the following summary of health problems, conditions, and medication use that may effect his/her ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with care for child(ren), ages 0-18, now and for the foreseeable future (five to ten years).

## I. HISTORY

1. Check any health problems:

| | | | |
|---|---|---|---|
| ___ Heart Problems | ___ Arthritis | ___ Depression | ___ Mental Illness |
| ___ Lung Problems | ___ Obesity | ___ Sleep Disorder | ___ Hepatitis |
| ___ Diabetes | ___ Poor Ambulation | ___ Confusion | ___ Allergies |
| ___ High Blood Pressure | ___ Weak/Frail | ___ Dementia | ___ Other |
| ___ Asthma | ___ Vision | ___ Epilepsy/Seizures | |
| ___ Kidney Disease | ___ Hearing | ___ Strokes/Paralysis | |

Explain ***all*** medical condition(s) checked and any other chronic conditions:
_____
_____

2. Are there any condition(s) that are progressive in nature? ___Yes ___ No
If yes, explain: _____
_____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next ____5 years, ____ 10 years, ____ 15 years? If yes, explain:
_____
_____

4. Medication(s):
_____
_____
_____

Are there any physical limitations as a result of medication(s)? ____Yes ____ No If yes, explain:
_____
_____

5. Illnesses/Injuries, Operations or Hospitalizations during the last 5 years:

| Illness/Injury | Operation | Hospitalization | Date | Outcome |
|---|---|---|---|---|
| | | | | |
| | | | | |

6. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

- Alcohol _____
- Drugs _____
- Tobacco _____
- Other _____

## II. PHYSICAL EXAMINATION

| HEIGHT | WEIGHT | TEMPERATURE | PULSE | BLOOD PRESSURE - INDICATE IF NORMAL |
|---|---|---|---|---|
| | | | | |

| | |
|---|---|
| HEART | LUNGS (INCLUDING TUBERCULIN (TB) SKIN TEST OR CHEST X-RAY RESULTS) |
| | |
| EYES | VISION |
| | |
| EARS | NOSE / THROAT |
| | |
| TEETH / GUMS | ABDOMEN |
| | |
| ENDOCRINE | PELVIS |
| | |
| NERVOUS SYSTEM | PAP SMEAR |
| | |
| RPR TEST | EXTREMITIES |
| | |
| DRUG SCREEN | |
| | |
| **CURRENT LABORATORY RESULTS:** | |
| URINALYSIS: SPECIFIC GRAVITY | ALBUMIN |
| MICROSCOPIC | GLUCOSE |
| **OTHER LABORATORY TEST (NAME, DATE AND RESULTS)** | |
| | |

Summary of abnormal physical findings that would affect caring for a child:

_____

_____

_____

## III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

1. Lift a child:
   Under 6 months ____Yes ____No
   6 months to 3 years ____Yes ____No
2. Walk/maneuver 50-100 feet without major difficulties: ____Yes ____ No
3. Bend/stoop, kneel, reach:
   ____ No
4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? ____Yes ____No
   If Yes, what type? _____
5. Are there any medical conditions which might limit this person's physical ability to care for a medically complex child which may include the ability to:

| | | | |
|---|---|---|---|
| Lift from a bed to a chair, etc. | ____ Yes | ____ No | ____ Don't Know |
| Frequent Feedings | ____ Yes | ____ No | ____ Don't Know |
| Frequent Suctions | ____ Yes | ____ No | ____ Don't Know |
| Frequent Monitoring | ____ Yes | ____ No | ____ Don't Know |
| Frequent Medications | ____ Yes | ____ No | ____ Don't Know |
| Frequent Nebulizations | ____ Yes | ____ No | ____ Don't Know |
| Frequent Treatments | ____ Yes | ____ No | ____ Don't Know |

Are any limiting conditions temporary? ____ Yes ____ No
If Yes, which condition(s):_____
For each condition, how long will the limitation exist?_____

## IV. CERTIFICATION / SIGNATURE

I certify that this individual is found free from symptoms of communicable disease.
____ Yes ____ No If No, explain: _____
_____
I certify that the individual has no physical or cognitive limitations that would prevent him/her from parenting.
____ Yes ____ No If No, explain: _____
_____

- With appropriate signed releases, I am available to discuss this report.

Physician's Signature: _____ Date: _____

State License Number: _____ Telephone:_____

Address: _____

 