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MEDICAL REPORT

Name:_____ Date of Birth_____ Date of Examination:_____

This form will aid Adoption Resources & Counseling, Inc. in determining the physical wellness and capabilities of adoptive parents who are, or may be, caring for children. Please complete the following summary of health problems, conditions, and medication use that may affect his/her ability to maintain alertness, endurance and performance of tasks and responsibilities associated with caring for children, ages 0 to 18, now and for the foreseeable future (five to ten years).

I. Medical History:

1. Please circle/indicate 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	
Asthma	Vision	Epilepsy/Seizures	
Kidney Disease	Hearing	Strokes/Paralysis	

Other _____

Explain all medical condition(s) circled and/or 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. Current medication(s) and reason for medication:

_____

_____

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

_____

Will these medications affect this person's ability to be a successful parent? Yes _____ No _____ If so, please explain:

_____

_____

5. Illness/Injury, operations or hospitalizations during the last five years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

6. Health Habits:
Is there a history of substances used by this applicant and what degree of impairment exists, if any, from the substance abuse?
Alcohol_____Drugs_____
Tobacco _____Other_____

Please complete a Standard Urine Drug Screen:** (example: 5, 6, 7 or 10 Panel Urine Drug Screen). ***Please attach results.

II. Physical Examination:

HEIGHT	**WEIGHT**	**TEMPERATURE**	**PULSE**	**BLOOD PRESSURE** Normal Abnormal

HEART	**LUNGS**
EYES	**VISION**
EARS	**NOSE/THROAT**
TEETH/GUMS	**ABDOMEN**
ENDOCRINE	**PELVIS**
NERVOUS SYSTEM	**EXTREMITIES**
URINE DRUG SCREEN (attach results):	**HIV** (attach lab results):

TB SKIN TEST OR CHEST X-RAY RESULTS (attach lab results):

OTHER LABORATORY TESTS (NAME, DATE AND RESULTS)

For Women: **RESULTS OF MOST RECENT PAP SMEAR** (physician can simply indicate "normal" (if abnormal please indicate results/re-test) – **no test results are required**):

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: Yes □ 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 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 Medication	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 conditions? _____

_____

For each condition, how long will the limitation exist? _____

_____

Are you aware of this person currently undergoing any personal or family counseling? If so, can you comment on the nature of the counseling?

_____

_____

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 her/him from parenting.
Yes □ No □ If no, explain:

_____

Please NOTE: (This form must be signed by a licensed medical physician and not an LNP, RN, PA, etc....)

Physician's Name (**Print**):_____ Date: _____

Physician's Signature:_____ State License Number:_____

Telephone:_____Address:_____