



DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
CHILDREN'S ADMINISTRATION

# Applicant Medical Report - CONFIDENTIAL

DATE
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MEDICAL PROVIDER			RETURN TO		
ADDRESS					
CITY	STATE	ZIP CODE			
NAME OF APPLICANT					DATE OF BIRTH

I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have initialed below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from date of my signature. **NOTE: Be sure to initial each line and sign.**

\_\_\_\_\_ mental illness, \_\_\_\_\_ alcohol and drug concerns, \_\_\_\_\_ sexual and/or physical abuse, \_\_\_\_\_ domestic violence.

\_\_\_\_\_ SIGNATURE OF APPLICANT \_\_\_\_\_ DATE

DATE FIRST SEEN BY PROVIDER	DATE OF LAST PHYSICAL EXAMINATION
SPECIALIST REFERRED TO	ADDRESS OF SPECIALIST

REASON FOR REFERRAL

SIGNIFICANT PAST MEDICAL HISTORY

CURRENT MEDICAL DIAGNOSIS

CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN.

PROGNOSIS

PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF CHILDREN.

COMMENTS OR IMPRESSIONS

MEDICAL PROVIDER'S SIGNATURE	DATE
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