PETITIONER(S) MEDICAL STATEMENT FOR ADOPTION

Patient Information (to be completed by patient or responsible adult)

Name	Relationship to Applicant	Date of Birth

Address (Street, City, State, Zip)

Are you currently taking any medication? If yes, please list medications and reason for use.

_____

_____

Have you ever been treated for any of the following? (Check all that apply)

☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Diabetes

☐ Emphysema ☐ Epilepsy ☐ Tuberculosis

☐ Alcohol Abuse ☐ Substance Abuse ☐ Mental Health Issues

☐ Current Communicable Disease ☐ Other serious or chronic illness

If any are checked, please explain: _____

_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my health care professional to release to the 13th Circuit Court or its agents information regarding my physical condition, mental health, and/or substance abuse services. I understand that completion of this form is required for the court to proceed with the adoption process.

_____

Patient or Responsible Adult Signature and Date

PHYSICAL EXAMINATION

Name	Date of Birth

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Date of physical examination	**Do you provide medical services to this individual:** ☐ **Regularly** ☐ **Occasionally** ☐ **First time**

Please respond to the following to the best of your knowledge:

1. Does this individual suffer from an illness including a communicable disease that would be detrimental to the care of a child placed in his/her home? ☐ Yes ☐ No
2. Are there any chronic or serious disorders for which this individual has been or is receiving treatment? ☐ Yes ☐ No
3. Is this individual currently taking medication? ☐ Yes ☐ No
4. If yes, could this medication adversely effect his/her ability to care for or be around children? ☐ Yes ☐ No
5. Has this individual been tested for TB? ☐ Yes ☐ No If yes, Date: _____
   Test Type: ☐ Skin Test ☐ X-Ray Results: ☐ Positive ☐ Negative
6. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a child placed in the home? ☐ Yes ☐ No
7. Have you ever referred this individual to other medical services, mental health services or treatment of alcohol/substance abuse? ☐ Yes ☐ No

If the answer to any of the above questions is **YES**, please explain: _____

_____

_____

Height _____ Weight _____ Heart _____ Blood Pressure _____

Lungs _____ Vision _____ Hearing _____ General Appearance _____

LABORATORY TESTS: **Tuberculin Test and/or X-Ray** **Date** _____ **Results** _____

Hemoglobin Date _____ Results _____

Urinalysis Date _____ Results _____

PHYSICIAN'S REMARKS ON HISTORY _____

_____

PRACTITIONER'S STATEMENT

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this home? Yes ☐ No ☐

Practitioner's Signature	Date	Practitioner's Printed Name	License Number

Address	Telephone Number