FOSTERADOPT CONNECT
18600 E. 37TH TERR., INDEPENDENCE, MO 64057

FOSTER/ADOPTIVE MEDICAL EXAM FOR PARENTS AND CHILDREN

To the Examining Physician: In evaluating the applicant, this agency must be guided by your medical findings, as reported on this form. To meet requirements of being a foster/kinship/relative and/or adoptive parent, the applicant(s) as well as their children must be in good physical and mental health. It is necessary to determine that the applicant has no communicable diseases, has a reasonable life expectancy and is capable, physically and emotionally, of carrying out the responsibilities of parenthood. With this in mind, please complete the following. The applicant's permission for release of information is given below.

Name of Examining Physician (please print)

Physician's Address:

Physician's Telephone Number:

APPLICANT'S RELEASE FOR INFORMATION

I, ______________________________, hereby give my permission for release of my complete
(SIGNATURE OF APPLICANT)
physical and mental condition to Midwest Foster Care & Adoption Association.

Patient's Name:	Date of Birth:

1. Past medical history (where applicable)- please check all that apply

☐ DIABETES	☐ ULCER	☐ TUBERCULOSIS	☐ MAJOR SURGERY (DATE) ________
☐ HEPATITIS	☐ CANCER	☐ CARDIAC PROBLEMS	☐ OTHER INFECTIOUS DISEASE

2. Note history of major illnesses and hospitalizations

3. Date of last physical exam: ____________________
4. Present medical conditions- check all that apply (note that tuberculosis testing should be completed for foster family applicants should the physician note specific concerns)

☐ DIABETES	☐ ULCER	☐ TUBERCULOSIS	☐ MAJOR SURGERY (DATE) ________
☐ HEPATITIS	☐ CANCER	☐ CARDIAC PROBLEMS	☐ OTHER INFECTIOUS DISEASE

5. Is patient under treatment for chronic illness? ☐ Yes ☐ No

If yes, what illness?

6. Is the patient following a treatment plan for chronic illness?

☐ Yes ☐ No

If yes, what treatment?

7. What medication(s) are prescribed?

8. Immunizations current?

☐ Yes ☐ No

If no, what immunizations are required?

9. Describe any specific factors for this patient that should be considered if care is given to children

10. Impressions of general physical health

☐ Superior ☐ Good ☐Poor

11. Impression of general mental health

☐ Superior ☐ Good ☐Poor

12. How long have you known the patient? ______________________________

13. From your knowledge, would you recommend this patient as foster/kinship/relative parent?

☐ Yes ☐ No ☐ Not applicable, child

14. From your knowledge, would you recommend this patient as an adoptive parent?

☐ Yes ☐ No ☐ Not applicable, child

15. I verify that the patient identified on this form is free from communicable diseases.

☐ Yes ☐ No If no, will this pose a medical threat to the household members ☐ Yes ☐ No

Signature of Physician

Date of Physical Examination