Reset Form

MEDICAL REPORT FOR CAREGIVERS

State Form 45145 (R4 / 4-11)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: This report must be completed by a licensed physician.

Applicable program *(check one)*:
☐ Foster family home ☐ Adoptive home

Name	Date of birth *(month, day, year)*

Address *(number and street, city, state, and ZIP code)*

This person has come to you in response to a request from this agency for a complete report on this person's physical condition. It is important for us to know of any health factors that might interfere with this person's ability to parent or provide care to a foster child or a child with special needs.

Are you the primary care physician? ☐ Yes ☐ No

If no, please provide the following information regarding the primary care physician.

Name of primary care physician	Telephone number ( )

Address *(number and street, city, state, and ZIP code)*

GENERAL HEALTH

Blood pressure	Date of last medical examination *(month, day, year)*	Height	Weight

MEDICAL HISTORY

Please list all medical professionals seen for treatment in the last year.

Name	Address *(number and street, city, state, and ZIP code)*	Telephone number

Is this person free from communicable or contagious disease (initial appropriate response)? ☐ Yes ☐ No

Please list all current medical conditions / diagnoses.

Please list all current prescription medications, including psychotropics. *(Attach additional documentation if necessary.)*

Name of Medication	Diagnosis	Dosage / Frequency

Do any of these medications cause any side effects that might interfere with this person's ability to perform any activities of daily living? ☐ Yes ☐ No

If yes, please explain. *(Attach additional documentation, if necessary.)*

MEDICAL HISTORY *(continued)*

Please describe how the above conditions / diagnoses / medications may impact the care of foster children.

ALCOHOL OR SUBSTANCE ABUSE

Is there any indication of alcohol or substance misuse / abuse? ☐ Yes ☐ No

In your professional opinion, do you believe it is necessary to request a drug and alcohol assessment or screen for this person? ☐ Yes ☐ No

Have you referred this person to a drug and alcohol assessment or screen? ☐ Yes ☐ No

If yes to any of the above, please explain.

Name of physician referred to	Telephone number ( )

Address *(number and street, city, state, and ZIP code)*

EMOTIONAL STABILITY

In your professional opinion, does this person have any current or past indicators of emotional instability? ☐ Yes ☐ No

If yes, please explain.

FERTILITY

What is the status of the applicant's current ability to conceive? *(Applies to adoptive applicants only.)*

Signature of examiner	Date signed *(month, day, year)*
Printed name	Title
Address *(number and street, city, state, and ZIP code)*	
Telephone number ( )	Date *(month, day, year)*