

Fax

[www.benchmarkfamilyservices.org](http://www.benchmarkfamilyservices.org/)

Medical Statement

For Foster Parents and All Household Members

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Authorization for Release of Information  I authorize the physician or licensed health care professional completing this form to release any information he/she may have concerning my physical or mental health to: Benchmark Family Services, at the above address. Further, I understand that by signing this form, I attest that the information provided herein is true and correct.  Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (If patient is under 18 years of age then the parent or guardian’s signature is required) |

Date of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please respond to each of the following questions to the best of your ability:

1. To your knowledge, does this individual suffer from any illness that would be detrimental to the care of a foster/adoptive child placed in his or her home?  Yes  No

2. To your knowledge, Is this individual physically able to provide necessary care for a foster child?  N/A  Yes  No

3. To your knowledge, are there any chronic disorders for which this individual has received treatment?  Yes  No

4. To your knowledge, is this individual currently taking medication? (If so please list current medications and reasons in the box below).  Yes  No

5. To your knowledge, is this individual experiencing any physical, behavioral, or emotional problems that would be detrimental to a foster/adoptive child placed in his or her home?

Yes  No

6. Have you ever referred this individual for mental health services or treatment for alcohol/substance abuse?  Yes  No

7. To your knowledge, is this individual up-to-date on their immunizations?

Yes  No

8. To your knowledge, does this individual suffer from a communicable or infectious disease that would present a health or safety risk to a child placed in his or her home?

Yes  No

|  |
| --- |
| If you answered YES to any of the above questions other than question #2, please explain: |

|  |
| --- |
| **Physician or Licensed Health Professional Signature: Date:** |
| State License Number: |
| Name of Physician or Licensed Health Professional (print or stamp): |
| Physician’s or Licensed Health Professional’s Address |
| Physician’s or Licensed Health Professional’s Phone Number: |
| Physician’s or Licensed Health Professional’s Fax Number: |

This Section to be Completed by the Applicant/Patient/Parent or Guardian

Health History

Do you have or have you ever had any of the following?

**GENERAL:** YES NO COMMENTS

Migraines or severe headaches   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures, Convulsions, Epilepsy   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes, Sugar in Blood or Urine   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unusual Lumps   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis, Joint Pain, Gout   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional Problems, Depression   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attempted Suicide   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EYES:**

Blurring, Changing Vision   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma, Cataracts   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EARS:**

Trouble Hearing, Ringing   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEART:**

Chest Pain, Shortness of Breath   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BLOOD/CIRCULATION:**

High Blood Pressure   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicose (Swollen) Veins   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Clots in Leg, Lung   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transfusions   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Cholesterol or Fat   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma, Pneumonia, Emphysema   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIVER:**

Hepatitis, Jaundice, Cirrhosis   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GALLBLADDER:**

Disease, Stones   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ABDOMEN:**

Ulcer, Pain   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BOWELS:**

Polyps, Blood in Stool   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KIDNEY OR BLADDER:**

Blood/Pus in Urine   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Infections   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stones   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXTREMITIES** (Arms, Hands, Legs, Feet)

Loss of Feeling, Tingling, Burning   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain, Swelling, Tenderness   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amputation   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is under 18 years of age then the parent or guardian’s signature is required)