

Fax

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Medical Statement

For Foster Parents and All Household Members

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

|  |
| --- |
| Authorization for Release of InformationI 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)