

MEDICAL STATEMENT FOR FOSTER CARE/ADOPTIVE APPLICANT AND ALL HOUSEHOLD MEMBERS

Name (LAST, FIRST, MIDDLE)	Date of Birth
Address (Street, City, State and ZIP)	

1. Have you had treatment for a serious or chronic illness? YES NO
 Have you been hospitalized in the past five years? YES NO
 Have you ever received, or been advised to seek, mental health services? YES NO
 Have you ever received, or been advised to seek, treatment for alcohol/substance abuse? YES NO
 If the answer to any of these questions is yes, please explain: _____

2. Have you or your parents, grandparents, or siblings had any of the following? (Check all that apply and indicate whom)
- | | |
|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Ulcers _____ |
- If any are checked, please explain: _____

3. Is there a history of other hereditary disease? YES NO
 If yes, please explain: _____

AUTHORIZATION FOR RELEASE OF INFORMATION	
I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing the reverse side of this form to release any information he/she may have concerning my physical or mental health to:	
_____ (Name of Agency)	
Signature of Applicant	Date

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION.