

**MEDICAL STATEMENT FOR FOSTER CARE/ADOPTIVE APPLICANT
AND ALL HOUSEHOLD MEMBERS (Continued)**

(This side of form to be completed by a licensed physician)

Date you last completed a physical examination of this individual:	Date you last treated this individual:
Do you provide medical services to this individual: <input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> First Time	

Please respond to each of the following to the best of your knowledge:

- Does this individual suffer from an illness, including a communicable disease, that would be detrimental to the care of a foster/adoptive child placed in his/her home?..... YES NO
- Are there any chronic or serious disorders for which this individual has received treatment?..... YES NO
- Is this individual currently taking medication?..... YES NO
- Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster/adoptive child placed in his/her home?..... YES NO
- Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse?..... YES NO

If the answer to any of the above questions is YES, please explain: _____

(For foster/adoptive applicant only, please complete.)

Please state your professional opinion regarding this individual's suitability as a foster/adoptive parent from the standpoint of health, considering the individual's medical history as given on the reverse side of this form and from knowledge you have of the individual.

Physician's Signature:	Date	Name of Physician (Print or Type):
		Physician's Work Address:
		Physician's Work Phone Number:
		Physician's State License Number: