Medical Report A

This form is to be completed as indicated by an applicant for, Foster Care, Relative Care, Pre-Adoption and Assisted Guardianship.

This information will only be re-disclosed with permission of applicant or by court order.

Full name: _____ Date of Birth: ____/____/____

Name and title of primary physician or practitioner: _____

Physician or practitioner address: _____

Please check the following items you have experienced or for which you have been treated. For any item checked, provide an explanation in the space provided. Include additional sheets if needed.

- ☐ 1. Physical limitations that may impact your ability to parent a child with special needs
- ☐ 2. Currently in treatment for a physical condition
- ☐ 3. Hearing, speech, or vision impairment
- ☐ 4. Psychiatric, mental or emotional condition, anxiety, or panic attacks.
- ☐ 5. You or your family currently in counseling
- ☐ 6. Difficulty walking or lifting
- ☐ 7. Kidney, bladder, or prostate disorder
- ☐ 8. Tuberculosis, asthma, emphysema, chronic bronchitis
- ☐ 9. High blood pressure, stroke
- ☐ 10. Heart disease (angina, valve problems, heart attack, heart failure, blood clots, abnormal heartbeat)
- ☐ 11. Ulcer, colitis, hepatitis
- ☐ 12. Diabetes, hypoglycemia, thyroid conditions
- ☐ 13. Muscular/skeletal disorders (arthritis, lupus, bursitis, disc problems, multiple sclerosis, muscular dystrophy, spinal injuries, joint injuries)
- ☐ 14. Allergies (food or environmental)
- ☐ 15. Surgeries or hospitalizations within the last year
- ☐ 16. Head Injuries, epilepsy (seizures), fainting spells, cerebral palsy
- ☐ 17. Cancer, leukemia, Hodgkin's disease, sickle cell disease, hemophilia
- ☐ 18. Infertility problems, miscarriage
- ☐ 19. Alcohol use
- ☐ 20. Had treatment for use of alcohol
- ☐ 21. Tobacco use
- ☐ 22. Use of an illegal drug within the last five years
- ☐ 23. Other

THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT UPON REQUEST

Explanation or Additional Information – attach more sheets if needed.

Are you currently taking any prescription or "over-the-counter" medications or substances? ☐ Yes ☐ No

Name	Dose	Reason

Please list any medications or substances that have been prescribed during the past five years for ongoing medical and/or psychological conditions:

Name	Dose	Reason

Family Health History

Yes	No		Relationship
☐	☐	Alcohol	_____
☐	☐	Drug Abuse	_____
☐	☐	Diabetes	_____
☐	☐	Cancer	_____
☐	☐	High Blood Pressure	_____
☐	☐	Heart Disease	_____
☐	☐	Psychiatric or Emotional Disorder	_____

✍ _____ _____

Signature of Applicant **Date**

Return to:

Worker's Name: _____ Branch: _____