MEDICAL STATEMENT FOR ALL ADOPTIVE APPLICANTS AND ALL HOUSEHOLD MEMERS

NAME (Last, First, Middle) ___________________________________**DOB**________________________

Address (Street, City, State, Zip)____

Have you had treatment for a serious or chronic illness?__________

Have you been hospitalized in the past 5 years?__________

Have you ever received or been advised to seek mental health services?____________

Have you ever received or been advised to seek treatment for alcohol/substance abuse____________

If you answered yes to any of the above, please explain____

____

Have you or your parents, grandparents, or siblings had any of the following? Y or N

Arthrits______ Heart Disease_________

Asthma______ Hypertension_________

Cancer_______ Kidney Disease________

Epilepsy______ Tuberculosis__________

Diabetes______ Ulcers_______________

If any are checked, please explain____

____

Is there a history of hereditary disease?____

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 second page of this form to release any information he/she may have concerning my physical or mental health to Lynn Barnett, LMSW for the purpose of completing a home study.

Lynn Barnett____

Signature of Applicant____**Date**____________________

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

Does this individual suffer from an illness, including communicable disease, that would be detrimental to the care of an adoptive child placed in his or her home?_______________

Are there any chronic or serious disorders for which this individual has received treatment?__________

Is this individual currently taking medication?_____________

Is this individual experiencing any physical, behavioral, or emotional problems that would be detrimental to an adoptive child placed in his or her home?___________________

Have you ever referred this individual to other medical services, mental health services, or treatment for alcohol/drug abuse?___________________

If the answer to any of the above is YES, please explain____

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Please state your professional opinion regarding this individual's suitability as an adoptive parent from the standpoint of health, considering the individual's medical history as given on the first page of this form and from the knowledge you have of the individual____

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Signature____Date_____________________

Name (print)____

Work Address____

Work Phone number_____________________________State License Number__________________________

Please check one of the following:

Licensed Physician____ Clinical Nurse Specialist____ Physician Assistant____Certified Nurse Practicioner____