



**Applicant Medical Report -
CONFIDENTIAL**

DATE

Section 1: Completed by Applicant and sent to Medical Provider

MEDICAL PROVIDER	PHONE NUMBER (AREA CODE)	RETURN TO CASE WORKER	
ADDRESS			
CITY	STATE	ZIP CODE	
NAME OF APPLICANT			DATE OF BIRTH

I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have initialed below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from date of my signature. **NOTE: Be sure to initial each line and sign.**

_____ mental illness, _____ alcohol and drug concerns, _____ sexual and/or physical abuse, _____ domestic violence.

SIGNATURE OF APPLICANT

DATE

Section 2: Completed by Medical Provider and sent to Case Worker Return Address above

DATE FIRST SEEN BY PROVIDER	DATE OF LAST PHYSICAL EXAMINATION	
DATE AND RESULTS OF LAST TB TEST	DATE OF LAST TDAP	DATE OF LAST INFLUENZA VACCINE
SPECIALIST REFERRED TO	ADDRESS OF SPECIALIST	
REASON FOR REFERRAL		
SIGNIFICANT PAST MEDICAL HISTORY INCLUDING CHRONIC / FREQUENT MEDICAL ISSUES		
CURRENT MEDICAL DIAGNOSIS		
CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN, AND HOW IT AFFECTS DAILY FUNCTIONING.		
PROGNOSIS		
PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF CHILDREN.		
COMMENTS OR IMPRESSIONS		
MEDICAL PROVIDER'S SIGNATURE	DATE	