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|  | LICENSING DIVISION (LD)**Applicant Medical Report****CONFIDENTIAL** |
| **Section 1: Completed by Applicant** |
| MEDICAL PROVIDER NAME | PHONE NUMBER | FAX NUMBER |
| ADDRESS OR NAME AND LOCATION OF MEDICAL OFFICE/PRACTICE/CLINIC |
| 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 checked 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 the date of my signature.**NOTE: Be sure to check each line and sign.**[ ]  mental health [ ]  sexual and/or physical abuse[ ]  alcohol and drug concerns [ ]  domestic violence |
| SIGNATURE OF APPLICANT | DATE |
| **Section 2: Completed by LD/CPA Staff** |
| LICENSOR NAME | LICENSING DIVISION OFFICE MAILING ADDRESS AND FAX NUMBER |
| **Section 3: Completed by Medical Provider. Return to local Licensing Division office listed in Section 2.**  |
| DATE OF MOST RECENT PHYSICAL EXAMINATION (**MUST BE WITHIN 12 MONTHS OF APPLICATION**)  | DATE FIRST SEEN BY PROVIDER   |

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| CHRONIC / FREQUENT MEDICAL ISSUES (INCLUDING SIGNIFICANT PAST MEDICAL HISTORY) |

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| CURRENT MEDICAL DIAGNOSIS |

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| 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  |

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| PROGNOSIS |

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| PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF ADDITIONAL CHILDREN |

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| COMMENTS/ IMPRESSIONS: IS THE APPLICANT CAPABLE OF CARING FOR AN ADDITIONAL CHILD OR CHILDREN? |

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| SPECIALIST REFERRED TO (IF APPLICABLE) | FAX NUMBER OF SPECIALIST (IF APPLICABLE) |

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| REASON FOR REFERRAL (IF APPLICABLE) |

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| **MEDICAL PROVIDER SIGNATURE** |
| MEDICAL PROVIDER NAME   | SIGNATURE | DATE |