Prospective Foster or Adoptive Parent Medical Evaluation Report

Name of Person Examined: _____ Exam Date: _____

Date of Birth: _____ Date of Report: _____

The Medical Evaluation Report is used as a component of the foster and adoptive caregiver approval process. It is used to ascertain a medical opinion on the caregiver's physical wellness and capabilities as it relates to the care of children. This includes problems, conditions, and medication use that may affect his/her ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and in the foreseeable future (five to ten years).

A tuberculosis (TB) test is a required evaluation component.

The report must be completed and signed by a licensed physician, physician's assistant or public health department personnel.

Height: _____ Weight: _____ Temperature: _____ Pulse: _____ Blood Pressure: _____

Is Blood Pressure normal? ☐ Yes ☐ No

Tuberculin (TB) Test Type ☐ Skin Test ☐ Blood Test ☐ Chest X-Ray

Tuberculin (TB) Test Results ☐ Positive ☐ Negative

Is a follow-up TB test required? ☐ No ☐ Yes, please explain: _____

Physical Examination

Were the physical exam results within normal limits? ☐ Yes ☐ No (If no, explain):

_____

Health History

1. Is the patient currently diagnosed with any disorders related to the following? ☐ No ☐ Yes — If yes, check any that apply

☐ Heart Problems	☐ Asthma	☐ Malingering	☐ Depression	☐ Epilepsy/Seizures
☐ Lung Problems	☐ Hearing	☐ Dementia	☐ Sleep Disorder	☐ Mental Illness
☐ Diabetes	☐ Arthritis	☐ Vision	☐ Cognition / Memory	☐ Hepatitis
☐ High Blood Pressure	☐ Obesity	☐ Strokes/Paralysis	☐ Kidney Disease	☐ Allergies

Other, or please explain any items checked: _____

_____

2. Is the patient prescribed any medications that impact their alertness, endurance or performance of tasks related to the care of children? ☐ No ☐ Yes (If yes, explain):

_____

3. Does the patient have any history of substance abuse?

☐ No ☐ Yes (If yes, please check appropriate box(es) and describe):

☐ Alcohol _____

☐ Prescription Drugs _____

☐ Other Drugs _____

☐ Other Substance _____

4. Does the caregiver smoke any form of tobacco? ☐ No ☐ Yes

Physical Capabilities

1. Does the patient have any physical limitations as it relates to the following?

a) Lifting a child age 0–3 years old ☐ Yes ☐ No

b) Walking/maneuvering without major difficulties ☐ Yes ☐ No

c) Bending/stooping, kneeling, reaching ☐ Yes ☐ No

d) Is an assistive device needed to walk, bend/stoop, kneel, or reach? ☐ Yes ☐ No (If yes, please explain):

_____

2. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to lift from a bed to chair, frequent feedings, suctioning or administering medications?

☐ Yes ☐ No ☐ Don't Know

If yes, please explain: _____

_____

Other Medical Requirements *(These vaccinations must remain up-to-date)*

(For caregivers who will care for children 0 to 24 months old)
Pertussis (Whooping Cough) Vaccination – Date of vaccination: _____ Expiration of vaccination: _____

(For caregivers who will care for children 0 to 24 months old and children with special medical needs)
Influenza (Flu) Vaccination – Date of vaccination: _____ Expiration of vaccination: _____

Physician's Certification

Approximately how long has the caregiver been a patient with your practice? _____

Were there any findings that would affect caring for a child now or in the foreseeable future, including any terminal illness?

☐ No ☐ Yes (If yes, explain): _____

_____

Does the patient have any diagnosed medical conditions that require on-going appointments (other than an annual physical)? ☐ No ☐ Yes (If yes, explain): _____

_____

Does the patient have any diagnosed medical condition that may impact their ability to care for children?

☐ No ☐ Yes (If yes, explain): _____

_____

Were there any results found in the medical examination not reported elsewhere that would have an impact on the care of children? ☐ No ☐ Yes (If yes, explain): _____

_____

Was the patient found to be free from symptoms of communicable disease? ☐ Yes ☐ No (If no, explain)

_____

Was the patient found to be free of physical or cognitive limitations that would impact child caregiving responsibilities?

☐ Yes ☐ No (If no, explain): _____

_____

Medical Personnel's Information

Licensed Physician's Name: _____ State License Number: _____

Physician's Assistant Name: _____

Public Health Personnel's Name: _____

Signature: _____ Date: _____

Office Name: _____

Address: _____

City, State, Zip Code: _____