MISSOURI DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S DIVISION

FOSTER/ADOPTIVE FAMILY MEDICAL REPORT

TO:
The Examining Physician

FROM:
Children's Division

In evaluating the applicant, this agency must be guided by your medical findings, as reported on this form. To meet requirements of being a foster and/or adoptive parent, the applicant, as well as all household members, must be in good physical and mental health. It is necessary to determine that the applicant has no communicable diseases, has a reasonable life expectancy and is capable, physically and emotionally, of carrying out the responsibilities of parenthood. With this in mind, please complete the following. The applicant's permission for release of medical information is given below.

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)

PHYSICIAN'S ADDRESS

PHYSICIAN'S TELEPHONE NUMBER

APPLICANT'S RELEASE FOR INFORMATION

I, _____ , hereby give my permission for release of my complete physical and mental
(SIGNATURE OF APPLICANT)

condition to _____ County Children's Division (CD) Office.

PATIENT'S NAME

DATE OF BIRTH

1. PAST MEDICAL HEALTH HISTORY (WHERE APPLICABLE) - PLEASE CHECK ALL THAT APPLY.

☐ DIABETES ☐ ULCER ☐ CANCER ☐ MAJOR SURGERY (DATE) _____
☐ HEPATITIS ☐ TUBERCULOSIS ☐ CARDIAC PROBLEMS ☐ OTHER INFECTIOUS DISEASE

2. NOTE HISTORY OF MAJOR ILLNESSES AND HOSPITALIZATIONS

3. DATE OF LAST COMPREHENSIVE PHYSICAL EXAM

4. PRESENT MEDICAL CONDITIONS - CHECK ALL THAT APPLY. (NOTE THAT TUBERCULOSIS TESTING SHOULD BE COMPLETED FOR FOSTER FAMILY APPLICANTS SHOULD THE PHYSICIAN NOTE SPECIFIC CONCERNS.)

☐ DIABETES ☐ ULCER ☐ CANCER ☐ MAJOR SURGERY (DATE) _____
☐ HEPATITIS ☐ TUBERCULOSIS ☐ CARDIAC PROBLEMS ☐ OTHER INFECTIOUS DISEASE

5. IS PATIENT UNDER TREATMENT FOR CHRONIC ILLNESS?

☐ YES ☐ NO IF YES, WHAT ILLNESS? _____

6. IS PATIENT FOLLOWING TREATMENT PLAN FOR CHRONIC ILLNESS?

☐ YES ☐ NO IF YES, WHAT TREATMENT? _____

7. WHAT MEDICATION IS BEING PRESCRIBED?

8. DESCRIBE ANY SPECIFIC FACTORS FOR THIS PATIENT THAT SHOULD BE CONSIDERED IF CARE IS GIVEN TO CHILDREN.

9. IMPRESSION OF GENERAL HEALTH

☐ SUPERIOR ☐ GOOD ☐ POOR

10. IMPRESSION OF GENERAL EMOTIONAL HEALTH

☐ SUPERIOR ☐ GOOD ☐ POOR

11. HOW LONG HAVE YOU KNOWN THE PATIENT?

12. FROM YOUR KNOWLEDGE, WOULD YOU RECOMMEND THIS PATIENT AS A FOSTER PARENT?

☐ YES ☐ NO

13. FROM YOUR KNOWLEDGE, WOULD YOU RECOMMEND THIS PATIENT AS AN ADOPTIVE PARENT?

☐ YES ☐ NO

DATE OF REPORT	SIGNATURE OF EXAMINING PHYSICIAN

Please mail completed forms in an envelope marked "CONFIDENTIAL" to:

_____ County Children's Division

Attention: Bringing Families Together

Address: 7151 N. Lindbergh Blvd

Hazelwood, MO 63042