Reset Form

MEDICAL REPORT FOR FOSTER AND/OR ADOPTION HOME APPLICANTS AND HOUSEHOLD MEMBERS

State Form 45145 (R5 / 3-23)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: This report must be completed by a licensed physician.

Patient's Name	Date of birth *(month, day, year)*

Purpose of Medical Report *(check one):*

☐ Foster Family Home Applicant ☐ Adoptive Home Applicant ☐ Relicensure ☐ Household Member of Applicant

☐ Other *(please describe):* _____

This person has come to you in response to a request from this agency for a complete report on this person's physical condition. It is important for us to know of any health factors that might interfere with this person's ability to parent, provide care to, and/or interact with a foster child or a child with special needs.

Are you the primary care physician? ☐ Yes ☐ No	*If no, please provide the following information regarding the primary care physician, if applicable.*
Name of primary care physician	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	
Date of last medical examination *(month, day, year)*	

MEDICAL HISTORY

Please list all medical professionals seen for treatment in the last year.

Name	Purpose / Specialty	Telephone Number and Address *(number and street, city, state, and ZIP code)*

Please list all current physical and/or mental health conditions or diagnoses.

Please list all current prescription medications, including psychotropics and/or regularly used over-the-counter medications and/or Cannabidiol (CBD)/Delta-8 products.

Name of Medication	Dosage / Frequency	Diagnosis / Reason / Purpose

Do any of these medications cause any side effects that might interfere with this person's ability to perform any activities of daily living? ☐ Yes ☐ No

If yes, please explain. *(Attach additional documentation, if necessary.)*

MEDICAL HISTORY *(continued)*

Please describe how the above conditions, diagnoses, and/or medications, or failure to follow treatment plans may impact the care of foster children.

COMMUNICABLE DISEASES

Is this person free from communicable or contagious disease?

☐ Yes ☐ No ☐ Undetermined

Is this person considered current on required immunizations?

☐ Yes ☐ No ☐ Undetermined

EMOTIONAL STABILITY

In your professional opinion, does this person have any current or past indicators of emotional instability?

☐ Yes ☐ No

If yes, please explain and provide contact information of the professional(s) this person was referred to.

CERTIFICATION

I hereby certify that all statement made in this medical report, and any attachments thereto, are correct to the best of my knowledge.

Signature of licensed physician	Date signed *(month, day, year)*

Printed name of licensed physician	Physician's State License number

Address *(number and street, city, state, and ZIP code)*

Telephone number

( )