MEDICAL REPORT FOR HOUSEHOLD MEMBERS

State Form 45144 (R2 / 3-06) / CW 0038

DEPARTMENT OF CHILD SERVICES

Check applicable program: ☐ Foster Home ☐ Adoptive Home

Name	
Address (*number and street*)	
City, state, and ZIP code	Date of birth (*month, day, year*)

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 interaction with a foster child or a child with special needs.

GENERAL HEALTH

Blood pressure	
Height	Weight

MEDICAL HISTORY

Does this person have any health, substance abuse and / or emotional factors which would interfere with the person's interaction with a foster child or a child with special needs?

☐ Yes ☐ No If yes, please explain below.

In your professional opinion, do you believe it is necessary to request a drug screen for this person?

☐ Yes ☐ No If yes, please explain below.

Have you referred the person for a drug screen?

☐ Yes ☐ No If yes, please explain below.

COMMUNICABLE & CONTAGIOUS DISEASES

Is this person free of communicable or contagious disease? (*initial appropriate response*) ☐ Yes ☐ No	Tuberculin test results (*last date*) (*month, day, year*)
	Chest x-ray, (*if necessary*)
	Other (*if applicable*):

Signature of examiner	Date signed (*month, day, year*)
Printed name and title of examiner	
Address (*number and street*)	
City, state, and ZIP code	
Telephone number ( )	Date of examination (*month, day, year*)