NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FOSTER-ADOPTIVE APPLICANT MEDICAL REPORT

To be by a physician, physician assistant, nurse practitioner or other licensed and qualified health care practitioner.
One form is to be completed for each applicant.

AGENCY:	
NAME OF PROSPECTIVE FOSTER/ADOPTIVE PARENT:	TELEPHONE NUMBER: ( ) -
ADDRESS OF PROSPECTIVE FOSTER/ADOPTIVE PARENT:	

I hereby request and authorize my physician to release the following information to the agency named above.

SIGNATURE OF PROSPECTIVE FOSTER/ADOPTIVE PARENT:
X

The above-named applicant has applied to foster or adopt a child. Per New York State regulations, we are required to obtain a medical report regarding the family's health. Such report must cover a physical examination of the applicant conducted not more than one year preceding the date the application for certification or approval is submitted to the certifying or approving agency.

Please respond to each of the following to the best of your knowledge:

Are there any chronic or serious disorders for which this individual has received treatment? ☐ No ☐ Yes

Is this individual currently taking medications? ☐ No ☐ Yes

Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substances abuse? ☐ No ☐ Yes

Please provide an explanation for any "yes" response.

GENERAL HEALTH REVIEW OF APPLICANT

PHYSICAL EXAM DATE: / /	HEIGHT: :	WEIGHT: LBS	BLOOD PRESSURE: /
VISION:		HEARING:	
CARDIOVASCULAR:		PULMONARY:	
GASTRO-INTESTINAL:		ENDOCRINE:	
NERVOUS SYSTEM:		MUSCULAR/SKELETAL:	
SKIN:			

Results of tuberculin test and/or chest x-ray (must be current)

DATE MANTOUX (TUBERCULIN) TEST GIVEN: / /	RESULTS OF MANTOUX TEST:

If chest x-ray or additional tests required provide test, date and results below:

Does the patient have any communicable disease, infection, illness or any physical condition which might affect the proper care of children? ☐ No ☐ Yes

Explain:

On the basis of my findings as indicated above, and my knowledge of the patient, I find the above listed individual is:

☐ Physically able to give adequate care to foster/adoptive children with no restrictions and no jeopardy to patient's health.

☐ Physically able to give adequate care to children with the following supports:

☐ Not physically able to give adequate care to children. Explain:

If the patient is an adoptive applicant, on the basis of my findings as indicated above, and my knowledge of the patient, I find the above listed individual: ☐ **IS** ☐ **IS NOT** in such physical condition that is reasonable to expect him/her to live to the child's majority and have the energy and other abilities needed to fulfill parental responsibilities.

PHYSICIAN'S SIGNATURE: X	TELEPHONE NUMBER: ( ) -	DATE SIGNED: / /
PHYSICIAN'S ADDRESS:		

RETURN COMPLETED REPORT TO:	AGENCY: