



MEDICAL REPORT FOR HOUSEHOLD MEMBERS

State Form 45144 (R3 / 1-11)
DEPARTMENT OF CHILD SERVICES

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

Applicable program (check one):	
<input type="checkbox"/> Foster home	<input type="checkbox"/> Adoptive home
Name	Date of birth (month, day, year)
Address (number and street, city, state, and ZIP code)	

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.

Are you the primary care physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, please provide the following information regarding the primary care physician.</i>
Name of primary care physician	Telephone number ()	
Address (number and street, city, state, and ZIP code)		

GENERAL HEALTH			
Blood pressure	Date of last medical examination (month, day, year)	Height	Weight

MEDICAL HISTORY
Please list any current physical or mental conditions or diagnoses or current medications that may impact this person's interaction with a foster child.

In your professional opinion, do you believe it is necessary to request a drug and alcohol assessment or screen for this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please explain.

Have you referred this person to a drug and alcohol assessment or screen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please explain.

Name of physician referred to	Telephone number ()
Address (number and street, city, state, and ZIP code)	

COMMUNICABLE DISEASES	
Is this person free from communicable or contagious disease (initial appropriate response)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of examiner	Date signed (month, day, year)
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Printed name	Title
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Address (number and street, city, state, and ZIP code)	
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Telephone number ()	Date of last examination (month, day, year)
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