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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICESCHILDREN’S DIVISION**FOSTER/ADOPTIVE HOUSEHOLD MEMBER PHYSICAL AND MENTAL HEALTH REPORT** |
| To the Examining Physician:       |
| From:      |
| Children’s Division |
| In evaluating the individual identified on this form, 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(s), **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 individual’s permission for release of medical information is given below. The patient must have been examined by the physician within the past twelve (12) months per 13 CSR 35-60.030(A). |
| Name of examining physician (please print)      |
| Physician’s Address      |
| Physician’s Telephone Number:       |

**APPLICANT’S RELEASE FOR INFORMATION**

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| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my permission for release of my complete  (SIGNATURE OF APPLICANT).physical and mental condition and any past or current substance abuse treatment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County Children’s Division (CD) Office |
| Patient’s Name       | Date of Birth      |

1. Past medical history (where applicable) – please check all that apply

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| --- | --- | --- | --- |
| [ ]  DIABETES | [ ] ULCER | [ ]  TUBERCULOSIS | [ ] MAJOR SURGERY (DATE)       |
| [ ]  HEPATITIS | [ ]  CANCER | [ ]  CARDIAC PROBLEMS | [ ] OTHER INFECTIOUS DISEASE |

2. Note history of major illnesses and hospitalizations

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3. Date of last 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)

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| [ ]  DIABETES | [ ]  ULCER | [ ]  TUBERCULOSIS | [ ]  MAJOR SURGERY (DATE)       |
| [ ]  HEPATITIS | [ ]  CANCER | [ ]  CARDIAC PROBLEMS | [ ]  OTHER INFECTIOUS DISEASE |

5. Is patient under treatment for chronic illness? [ ] Yes [ ] No

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| If yes, what illness? |

6. Is the patient following a treatment plan for a chronic illness?

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| [ ]  Yes [ ]  No  |
| If yes, what treatment? |

7. What medication(s) prescribed?

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8. Immunizations current?

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| --- |
| [ ]  Yes [ ]  No |
| If no, what immunizations are required? |
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9. Past substance abuse treatment?

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| --- |
| [ ]  Yes [ ]  No  |
| If yes, what treatment and outcome? |

10. Current substance abuse treatment?

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| --- |
| [ ]  Yes [ ]  No  |
| If yes, what treatment and outcome? |

11. Describe any specific factors for this patient that should be considered if care is given to children

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12. Impression of general physical health

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| [ ]  Superior [ ]  Good [ ]  Poor |

13. Impression of general mental health

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| --- |
| [ ]  Superior [ ]  Good [ ]  Poor |

14. How long have you known the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. From your knowledge, would you recommend this patient as a foster parent?

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| [ ]  Yes [ ]  No [ ]  Not applicable, child or household member |

16. From your knowledge, would you recommend this patient as an adoptive parent?

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| [ ]  Yes [ ]  No [ ]  Not applicable, child or household member |

17. I verify that the patient identified on this form is free from communicable diseases.

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| [ ]  Yes [ ]  No |
| If no, will this pose a medical threat to the household members [ ]  Yes [ ]  No |
| Date of Physical Examination |
| Signature of physician |

PLEASE MAIL COMPLETED FORM IN AN ENVELOPE MARKED “**CONFIDENTIAL**” TO:

      County Children’s Division

Attention:

Address: