MEDICAL STATEMENT FOR FOSTER HOME LICENSING/ADOPTION

(For Applicant and all Household members)

Michigan Department of Human Services

Family Name	Date

Patient Information (to be completed by patient or responsible adult)

Name	Relationship to Applicant	Date of Birth
Address (Street, City, State, Zip)		

Are you currently taking any medication? If yes, please list medications and reason for use.

_____

_____

Have you ever been treated for any of the following? (Check all that apply)

☐ Heart Disease ☐ Kidney Disease ☐ Cancer ☐ Diabetes

☐ Emphysema ☐ Epilepsy ☐ Tuberculosis

☐ Alcohol Abuse ☐ Substance Abuse ☐ Mental Health Issues

☐ Current Communicable Disease ☐ Other serious or chronic illness

If any are checked, please explain: _____

_____

_____

If you <u>have</u> checked any of the above, please have page 2 of this form completed by your licensed physician, physician's assistant or nurse practitioner.

If you <u>have not</u> checked any of the above, please have your licensed physician, physician's assistant or nurse practitioner read and sign the following statement:

MEDICAL PRACTITIONER'S STATEMENT

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for foster care or adoption? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's printed name
Address		Telephone Number ( )

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my health care professional to release to the Michigan Department of Human Services or its agents information regarding my physical condition, mental health, and/or substance abuse services. I understand that completion of this form is required for the agency to proceed with the adoption/foster home licensing process.

_____

Patient or Responsible Adult Signature and Date

PHYSICAL EXAMINATION

Michigan Department of Human Services

Name	Date of Birth

TO BE COMPLETED BY LICENSED PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Date of physical examination	**Do you provide medical services to this individual:** ☐ **Regularly** ☐ **Occasionally** ☐ **First time**

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

1. Does this individual suffer from an illness including a communicable disease that would be detrimental to the care of a foster child/adoptive child placed in his/her home? ☐ Yes ☐ No
2. Are there any chronic or serious disorders for which this individual has been or is receiving treatment? ☐ Yes ☐ No
3. Is this individual currently taking medication? ☐ Yes ☐ No
4. If yes, could this medication adversely effect his/her ability to care for or be around children? ☐ Yes ☐ No
5. Has this individual been tested for TB? ☐ Yes ☐ No If yes, Date: _____
   Test Type: ☐ Skin Test ☐ X-Ray Results: ☐ Positive ☐ Negative
6. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster child/adoptive child placed in the home? ☐ Yes ☐ No
7. Have you ever referred this individual to other medical services, mental health services or treatment of alcohol/substance abuse? ☐ Yes ☐ No

If the answer to any of the above questions is **YES**, please explain: _____

Height _____ Weight _____ Heart _____ Blood Pressure _____

Lungs _____ Vision _____ Hearing _____ General Appearance _____

LABORATORY TESTS: **Tuberculin Test and/or X-Ray** **Date** _____ **Results** _____

Hemoglobin Date _____ Results _____

Urinalysis Date _____ Results _____

PHYSICIAN'S REMARKS ON HISTORY _____

PRACTITIONER'S STATEMENT

In your opinion, are there any physical or mental factors that would jeopardize the physical or mental welfare of any child placed in this family for foster care and/or adoption? ☐ Yes ☐ No

Would you like to be contacted by the foster home licensing/adoption worker regarding your recommendation? ☐ Yes ☐ No

Practitioner's Signature	Date	Practitioner's Printed Name	License Number

Address	Telephone Number