South Carolina Department of Social Services

MEDICAL REPORT FOR PROSPECTIVE FOSTER/ADOPTIVE PARENT

Name of Person Examined: _____ Birthdate: _____

I hereby authorize _____ to release the medical information contained on this form
Licensed Medical Practitioner
to SC DSS.

Patient's Signature: _____ Date: _____

To the Examining Physician: This report will aid DSS in determining the capabilities of adults who are applying to become foster and/or adoptive parents. Please complete the following summary of health conditions and medication use.

Medical History

Check any of the following conditions the patient has or has had in the past.

- ❑ Mental Illness
- ❑ Impaired Hearing
- ❑ Impaired Sight
- ❑ Any Surgical Operations
- ❑ Depression
- ❑ Orthopedic Defects
- ❑ Chemical Dependence
- ❑ Cancer
- ❑ Hypertension
- ❑ Allergies
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Other Medical Condition
- ❑ Ulcers
- ❑ Heart Disease
- ❑ Neurosis
- ❑ Epilepsy
- ❑ STD
- ❑ Communicable Diseases (HIV+, Hepatitis B, other)

Please explain how any of this person's health conditions may affect their ability to provide adequate care for up to 5 children, ages birth to 18, now and for the foreseeable future (5-10 years). **If there are conditions that affect the patient's mental or emotional stability, please explain in detail:**

_____

_____

_____

_____

_____

_____

_____

_____

Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____

Eyes: _____

Ear, Nose, Throat: _____ Cholesterol Reading: _____

Heart: _____ Lungs: _____

* Please complete front and back of form *

1. Current medications and reason prescribed.

Medication	Reason Prescribed
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

2. Medications not listed above that have been prescribed in the past six months.

3. Are there any conditions that are chronic or progressive in nature that would interfere with this person's ability to care for a child in the next ❑ 5 years, ❑ 10 years, ❑ 15 years? If yes, please explain.

4. Please list illness/injuries, operations or hospitalizations during the last 5 years.

5. Have you ever provided any medical statement/evaluation in order for this person to apply for disability/workman's compensation or have you provided any other medical related excuse? If so, when? _____

6. How long have you known this patient? _____

Physician's Certification/Signature

7. I certify that this individual is free from symptoms of communicable disease.

   ❑ Yes ❑ No If no, please explain: _____

8. I certify that the individual has no physical or cognitive limitations that would prevent him/her from parenting.

   ❑ Yes ❑ No If no, please explain: _____

Physician's Printed Name: _____

Physician's Signature: _____ **Date:** _____

Address: _____

Phone: _____