

South Carolina Department of Social Services
MEDICAL REPORT FOR PROSPECTIVE FOSTER/ADOPTIVE PARENT

Name of Person Examined: _____ Birthdate: _____

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

Patient's Signature: _____ Date: _____

To the Examining Licensed Medical Practitioner: 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.

- | | | |
|--|--|---|
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Impaired Hearing | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Impaired Sight | <input type="checkbox"/> Allergies | <input type="checkbox"/> Neurosis |
| <input type="checkbox"/> Any Surgical Operations | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> STD |
| <input type="checkbox"/> Orthopedic Defects | <input type="checkbox"/> Other Medical Condition | <input type="checkbox"/> Communicable Diseases (HIV+, Hepatitis B, other) |
| <input type="checkbox"/> Chemical Dependence | | |

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: _____ Date of Examination: _____

* 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? _____

Licensed Medical Practitioner 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: _____

Licensed Medical Practitioner's Printed Name: _____

Licensed Medical Practitioner's Signature: _____ **Date:** _____

Address: _____

Phone: _____