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.

Yes	No	Condition
		Mental Illness
		Impaired Hearing
		Impaired Sight
		Surgical Operations
		Depression
		Orthopedic Defects
		Chemical Dependence
		Cancer
		Hypertension
		Allergies
		Diabetes
		Tuberculosis
		Ulcers
		Heart Disease
		Neurosis
		Epilepsy
		STD
		Communicable Diseases (HIV+, Hepatitis B, other)
		Other:

If yes, please provide a detailed explanation and prognosis of the condition:

Physical Examination

Height:_____ Weight:_____ Blood Pressure: _____

Eyes: _____ Ear, Nose, Throat:_____ Cholesterol Reading: _____

Heart:_____ Lungs: _____ Date of Examination:_____

* Please complete pages 1 and 2 *

1. Current medications and reason prescribed.

Medication	Reason Prescribed
1.	
2.	
3.	
4.	
5.	

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? 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 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? _____

7. Has the patient had an annual flu shot? ☐ Yes ☐ No If yes, date given? _____

8. Has the patient been vaccinated for whooping cough within the past 10 years? ☐ Yes ☐ No If yes, date given? _____

Physician's Certification/Signature

9. I certify that this individual is free from symptoms of communicable disease.
☐ Yes ☐ No If no, please explain: _____

10. 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: _____