South Carolina Department of Social Services

MEDICAL REPORT FOR CHILD

Name of Child Examined:_____Birthdate:_____

I hereby authorize_____to release the medical information contained on this form
Licensed Medical Practitioner

to SCDSS.

Signature of Parent:_____Date: _____

To the Examining Licensed Medical Practitioner: This report will provide SCDSS the health of all household members of a prospective foster/adoptive family and to assess the entire household's ability to care for a child.

Physical Examination:

Height:_____Weight:_____Blood Pressure (over age 3): _____

Temperature: _____ Date of Examination: _____

Comprehensive Health, Behavioral, and Development Assessment/History: (document any known chronic health problems, medications, allergies, significant acute illnesses, language, social, psychomotor skills, behavioral issues, and prenatal history of the child)

Assessment of Nutritional Adequacy and Overall Well-Being:

Has the patient had an annual flu shot (if old enough)? ___yes ____no if yes, date given:_____

Is the patient's immunizations current for his/her age? ____yes ____no if no, which immunization(s) are needed?_____

Please attach a copy of the patients immunization record to this medical

Licensed Medical Practitioner's Printed Name: _____

Licensed Medical Practitioner's Signature:_____Date:_____

Address: _____

_____

Phone: _____