1605 Eustis Street
Saint Paul, MN 55108
800.952.9302 | 651.646.7771 | chlss.org

MEDICAL EXAMINATION REPORT | CHILD

Applicant Name ______________________________________

Child's Name Addressed in this Report ____________________

Date of Birth of Child Addressed in this Report ______________

Relationship to Applicant (Please check one)

Birth Step Adopted Other

Please return completed form to:

Children's Home & LSS
c/o Domestic Program Specialist
1605 Eustis Street
Saint Paul, MN 55108
Fax: 651.255.2292

I agree that the findings of this report be shared with CH/LSS. This consent is valid for one year from the date of signature.

PERSON IN REPORT | Signature____________________ Printed Name ______________________ Date ______________

If the person addressed in this report is a minor, please include the signature of their guardian.

________ *I authorize Children's Home Society & Lutheran Social Service to have ongoing written & verbal contact with*
Initials *this provider listed in this report.*

________ *I certify that I have retained a copy of this signed document for my own records.*
Initials

Please have a ***medical provider/physician*** *complete the following report for all children of the applicants for adoption.*

PRESENT CONDITION

Date of Examination _____________ How long have you been seeing this child? ______________________________

Weight ________________________ Height _____________________________ Sex ☐ Male ☐ Female

Current Medication(s) (list all)

Purpose of Medication(s)

Please describe (in full sentence/s) the general health and development of this child:

MEDICAL HISTORY

Please record any serious illness/surgeries the child has had (or may have), including dates:

Has the child ever been hospitalized?	Yes	No
Has the child ever had major surgery?	Yes	No
Has the child ever been treated for emotional problems/mental illness?	Yes	No

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Has the child ever been treated for chemical dependency? Yes No

Is the child free from communicable/contagious disease? Yes No

Based on the available information, can the individual be considered free of tuberculosis in a communicable form? Yes No

Please initial below for each description that applies to this child.

_______ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_______ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_______ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_______ The individual had a chest x-ray on ____________________ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

IMMUNIZATION HISTORY

TYPE OF IMMUNIZATION	DATE OF LAST VACCINE/DOSE (Month, Day, Year)
Diphtheria, Tetanus, Pertussis (DTP)	
Polio (IPV and/or OPV)	
Measles, Mumps, Rubella (MMR)	
Haemophilus Influenzae Type B (HiB)	
Varicella (Chickenpox)	
Pneumococcal Conjugate Vaccine (PCV)	
Hepatitis B (Hep B) – Required for kindergarten	

The patient or the parent/guardian of this minor patient (if applicable):

is not opposed to immunizations.

is conscientiously opposed to all immunizations.

is conscientiously opposed to only the immunizations indicated below:

____

PROVIDER INFORMATION

License Number ____

Clinic Name ____

Clinic Address ____

To the best of my knowledge, I have disclosed all health-compromising information about the above-named child.

PHYSICIAN | Signature______________________________ Printed Name ______________________________ Date _______________