

Foster Care & Adoption | Medical Exam Report

PERSON TO BE ADDRESSED IN THIS REPORT:

Patient's Name _____

Patient's Date of Birth _____

I agree that the findings of this report be shared with Children's Home & LSS, LLC. This consent is valid for one year from the date of signature. I authorize Children's Home to have ongoing written and verbal contact with the provider listed below. I understand and agree that my electronic signature is the legal equivalent of my manual/handwritten signature on this document and is as valid as if I signed the document in writing.

 Signature of patient or parent/guardian if patient is a minor

 Date

RETURN COMPLETED FORMS TO:
FCAapplications@chlss.org

Fax: 651.646.0436

Please have a medical provider/physician complete the following report for the above-named patient.

Date of Last Exam _____ How long has this patient been known to you? _____

Current Medication(s) (list all)

MEDICATION NAME	DOSAGE	PURPOSE/DIAGNOSIS TREATED
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach additional pages if medication does not fit above.

PATIENT HISTORY

 Does this patient have a history of any of the following? *(please check either Yes or No for each item)*

- | | | |
|---|-----|----|
| • Children Only: Is this patient up to date on immunizations? | Yes | No |
| • Does the patient have a history of any significant disease or chronic condition? | Yes | No |
| • Has the patient ever been hospitalized in the last 5 years? | Yes | No |
| • Has the patient received mental health treatment in the last 5 years? | Yes | No |
| • Has the patient ever been treated for chemical dependency? | Yes | No |
| • Adults Only: Has the patient undergone infertility tests and/or treatment? | Yes | No |

If the answer to any of the previous questions is **"Yes"** please provide date(s)/circumstance(s) or occurrence(s), short-term and/or long-term prognosis. **For adults**, please also list any implications this might have on the patient's functional ability to parent.

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

Physician Signature _____

Date _____

Printed Physician Name: _____ Clinic Name & Address: _____