Children's Home Society of Minnesota
Lutheran Social Service of Minnesota

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

MEDICAL EXAMINATION REPORT

Applicant Name _____

Name of Person Addressed in this Report _____

Date of Birth of Person Addressed in this Report _____

Relationship to Applicant _____

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 this provider listed in this report.***
Initials

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

PRESENT CONDITION

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

Weight _____ Height _____ Blood Pressure _____ Heart Rate _____

Maintenance Medication (list all) _____

General physical condition; if applicable, include two most recent HbA1 levels_____

Your impression of the patient's emotional health and maturity

PATIENT HISTORY

Does the patient have a history of any of the following? *(Please check either "yes" or "no" for each item.)*

Tuberculosis	☐ Yes	☐ No	Neurological Disability	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Injuries	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Infertility	☐ Yes	☐ No

Does the patient have a history of any significant disease or chronic condition? ☐ Yes ☐ No

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Has the patient ever been hospitalized? ☐ Yes ☐ No

Has the patient ever been treated for emotional problems/mental illness? ☐ Yes ☐ No

Has the patient ever been treated for chemical dependency? ☐ Yes ☐ No

If the answer to any of the previous questions is "yes," please provide date(s)/circumstance(s) or occurrence(s), as well as any implications this might have on the patient's functional ability to parent (if this report addresses one of the applicants for adoption) in the space below.

If applicable, please list the date and outcome of any pregnancies this patient has experienced.

PROVIDER INFORMATION

License Number _____

Clinic Name _____

Clinic Address _____

Clinic Phone Number _____

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

PHYSICIAN | Signature_____ Printed Name _____ Date _____