Children's Home Society of Minnesota
Lutheran Social Service of Minnesota
1605 Eustis Street, Saint Paul, MN 55108
infantapp@chlss.org | chlss.org

Domestic Infant Adoption | Medical Exam Report (Child)

CHILD TO BE ADDRESSED IN THIS REPORT *(COMPLETED BY PARENT):*

Child's Full Name _____

Child's Date of Birth _____

Parent's Name _____

RETURN COMPLETED FORMS TO :

Children's Home & LSS
ATTN: Domestic Infant Adoption Program
1605 Eustis Street, Saint Paul, MN 55108
infantapp@chlss.org | Fax: 651.646.0436

I agree that the findings of this report can be shared with Children's Home & Lutheran Social Service of Minnesota. I authorize Childre's Home & LSS to have ongoing written and verbal contact with the provider listed below. This consent is valid for one year from the date of signature. 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.

Parent's Signature _____ Date _____

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

PRESENT CONDITION

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

Weight _____ Height _____ Blood Pressure _____ Heart Rate _____

Impression of the general health and development:

Current Medication(s) (list all)

MEDICATION NAME	DOSAGE	PURPOSE/DIAGNOSIS TREATED

Please attach additional questions 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)*

- Is this patient up to date on immunizations? ☐ Yes ☐ No
- Has the patient ever had a serious illness or surgery? ☐ 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

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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, as well as any implications on functioning.

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

PHYISICAN | Signature _____ Date_____

Physician Name:

Clinic Name & Address:

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