



MEDICAL REPORT FOR HOUSEHOLD MEMBERS

State Form 45144 (R4 / 11-15)
DEPARTMENT OF CHILD SERVICES

INSTRUCTIONS: This report must be completed by a licensed physician.

Applicable program (<i>check one</i>):	
<input type="checkbox"/> Foster home	<input type="checkbox"/> Adoptive home
Name	Date of birth (<i>month, day, year</i>)
Address (<i>number and street, city, state, and ZIP code</i>)	

This person has come to you in response to a request from this agency for a complete report on this person's physical condition. It is important for us to know of any health factors that might interfere with this person's interaction with a foster child or a child with special needs.

Are you the primary care physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, please provide the following information regarding the primary care physician.</i>
Name of primary care physician	Telephone number ()	
Address (<i>number and street, city, state, and ZIP code</i>)		

GENERAL HEALTH			
Blood pressure	Date of last medical examination (<i>month, day, year</i>)	Height	Weight

MEDICAL HISTORY
Please list any current physical or mental conditions or diagnoses or current medications that may impact this person's interaction with a foster child.
.....
.....
.....

In your professional opinion, do you believe it is necessary to request a drug and alcohol assessment or screen for this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

If yes, please explain.
.....
.....

Have you referred this person to a drug and alcohol assessment or screen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

If yes, please explain.
.....
.....

Name of physician referred to	Telephone number ()
Address (<i>number and street, city, state, and ZIP code</i>)	

COMMUNICABLE DISEASES	
Is this person free from communicable or contagious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If this report is for a child, are immunizations current?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of examiner	Date signed (<i>month, day, year</i>)
Printed name	Title
Address (<i>number and street, city, state, and ZIP code</i>)	
Telephone number ()	Date of last examination (<i>month, day, year</i>)