Resource Parent Medical Report

*Our client has come to you in response to a request from this agency for a report on his/her physical condition. It is important for us to know of any health factors or communicable diseases, which may interfere with his/her ability to care for a child.*

**I. GENERAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| **PATIENT NAME:** | **DATE OF BIRTH:** | **SEX:** |
| **HEIGHT:** | **WEIGHT:** | **BLOOD PRESSURE:** |
| **TB TEST DATE:** | **TB TEST READ DATE:** | **TB TEST RESULTS (MM):**  |

**II. SIGNIFICANT MEDICAL CONDITIONS OF PATIENT (\*Please check yes or no for each)**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO** | **CONDITION** | **If yes, explain and list medication taken for the condition**  |
|  |  | Alcohol |  |
|  |  | Allergies |  |
|  |  | Arthritis |  |
|  |  | Asthma  |  |
|  |  | Cancer |  |
|  |  | Chemical Dependency |  |
|  |  | Cigarette |  |
|  |  | Cholesterol |  |
|  |  | Chronic Pain/fatigue |  |
|  |  | Communicable/Infectious Diseases |  |
|  |  | Drugs – other |  |
|  |  | Diabetes |  |
|  |  | Digestive Disorder |  |
|  |  | Epilepsy |  |
|  |  | Hearing Impairment |  |
|  |  | Heart Ailment |  |
|  |  | Hepatitis |  |
|  |  | Hypertension |  |
|  |  | Mental Illness |  |
|  |  |  Depression |  |
|  |  |  Bi-polar |  |
|  |  |  Schizophrenia |  |
|  |  |  Anxiety |  |
|  |  |  Psychiatric Hospitalization  |  |
|  |  | Migraine Headaches  |  |
|  |  | Musculoskeletal Disorder |  |
|  |  | Neuromuscular Disorder  |  |
|  |  | Orthopedic Condition |  |
|  |  | Renal Illness |  |
|  |  | Respiratory Illness |  |
|  |  | Seizure Disorder  |  |
|  |  | Skin Disorder |  |
|  |  | Thyroid |  |
|  |  | Vision Impairment |  |
|  |  | Other: |  |

**III. Please list any medications *(prescription or over-the-counter)* NOT LISTED ABOVE that the patient is currently taking or prescribed and for what purpose:**

**IV. Based on your evaluation:**

* **Do you feel this patient is free of any physical condition that might unfavorably affect a foster or adoptive child?**
* **Is this patient free from Communicable/Infectious disease? Yes \_\_\_ No \_\_\_ If no, explain:**
* **What is the patient’s prognosis for continued health?**
* **Do you feel this patient is mentally competent to parent a child?**
* **Do you feel further mental health or psychological evaluations are necessary for you to make the aforementioned determination? *\*Please provide recommendation as to any follow up or additional testing you find necessary.***

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| **EXAMINING PRACTITIONER’S SIGNATURE:** |
| **EXAMINING PRACTITIONER’S PRINTED NAME:** |
| **NAME and ADDRESS OF PRACTICE:** |
| **TELEPHONE NUMBER:** |
| **DATE OF EXAMINATION:** |