NAME OF APPLICANT(S):

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FOSTER/ADOPTIVE APPLICANT MEDICAL REPORT (PART ONE)

Instructions:

Applicant: There are three sections to this form. **Section 1** is to be completed by the applicant. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for the applicant.

Home finder: This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant. Provide one form per applicant.

PART ONE - SECTION 1: APPLICANT'S INFORMATION

NAME OF APPLICANT:

LAST, FIRST, MIDDLE INITIAL:	DATE OF BIRTH: / /	TELEPHONE NUMBER: ( ) -
ADDRESS OF APPLICANT:		

I hereby request and authorize my physician to release the following information to the agency named below.

APPLICANT'S SIGNATURE:
X

The above-named applicant has applied to foster or adopt a child(ren). Per New York State regulations, the agency is required to obtain a medical report regarding the family's health. Such report must cover a physical examination of the applicant conducted not more than one year preceding the date the application for certification or approval is submitted to the certifying or approving agency.

SECTION 2: AGENCY'S INFORMATION

AGENCY'S NAME:

AGENCY'S ADDRESS:

AGENCY'S CONTACT (NAME AND PHONE NUMBER):

SECTION 3: To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each applicant.

Please respond to each of the following to the best of your knowledge:

Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment?	☐ No ☐ Yes
Is this individual currently taking medications?	☐ No ☐ Yes
Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse?	☐ No ☐ Yes

Please provide an explanation for any "Yes" response.

GENERAL HEALTH REVIEW OF APPLICANT

PHYSICAL EXAM DATE: / /	HEIGHT: :	WEIGHT: LBS	BLOOD PRESSURE: /

VISION:	HEARING:
CARDIOVASCULAR:	PULMONARY:
GASTROINTESTINAL:	ENDOCRINE:
NERVOUS SYSTEM:	MUSCULAR/SKELETAL:
SKIN:	

Results of tuberculin test and/or chest X-ray (must be current)

DATE MANTOUX (TUBERCULIN) TEST GIVEN: / /	RESULTS OF MANTOUX TEST:

NAME OF APPLICANT(S):

If chest X-ray or additional tests are required, provide test, date, and results below:

Does the individual have any communicable disease, infection, illness, or any physical condition that might affect the proper care of child(ren)? ☐ No ☐ Yes

Explain:

FINDINGS

On the basis of my findings, as indicated above, and my knowledge of the individual, I find the above listed individual is:

☐ Physically able to give adequate care to foster/adoptive child(ren) with no restrictions and no jeopardy to individual's health.

☐ Physically able to give adequate care to foster/adoptive child(ren) with the following supports:

☐ Not physically able to give adequate care to foster/adoptive child(ren). Explain:

If the individual is an adoptive applicant, on the basis of my findings, as indicated above and my knowledge of the individual, I find the above-listed individual: ☐ **IS** ☐ **IS NOT** in such physical condition that it is reasonable to expect him/her to live to the child(ren)'s majority and have the energy and other abilities needed to fulfill parental responsibilities.

MEDICAL CARE PROVIDER'S SIGNATURE:	TELEPHONE NUMBER:	DATE SIGNED:
X	( ) -	/ /

MEDICAL CARE PROVIDER'S ADDRESS:

PHYSICIAN'S STAMP:

RETURN COMPLETED REPORT TO AGENCY CONTACT LISTED IN SECTION 2.