NAME OF APPLICANT(S):

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

HOUSEHOLD MEMBER MEDICAL REPORT (PART TWO)

Instructions:

Applicant(s): There are three sections to this form. **Section 1** is to be completed by the applicant if household member is under 18 years of age or by the household member if 18 years of age or older. **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 each household member.

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

PART 2 - SECTION 1: HOUSEHOLD MEMBER'S INFORMATION

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

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

HOUSEHOLD MEMBER OR PARENT/GUARDIAN IF HOUSEHOLD MEMBER IS UNDER 18 YEARS OF AGE SIGNATURE:	DATE:
X	/ /

The above-named individual(s) is residing in the home of an individual(s) who is seeking 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 show that each member of the household is in good physical and mental health and free from communicable diseases.

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 household member of an applicant(s).

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

Please provide an explanation for any "Yes" response.

Is the above-listed individual in good physical and mental health, and free from communicable diseases?	☐ No	☐ Yes

Please provide an explanation for "No" response.

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.