CONFIDENTIAL ADOPTIVE APPLICANT MEDICAL REPORT **CONFIDENTIAL**

PLEASE RETURN TO: Forever Families Home Study Agency

Forever Families Home Study Agency, Inc.
P.O. 1195
Goldenrod, Florida 32733-1195

APPLICANT: I authorize my health care provider, _____, to disclose all medical information, including past records and treatments, to Forever Families. I understand that my medical records and reports regarding current medical condition(s) may contain information regarding the diagnosis or treatment of HIV/AIDS or other sexually transmitted diseases, drug and/or alcohol abuse and mental illness or psychiatric treatment. I specifically authorize my health care provider to disclose this and all other medical information to Forever Families. I agree to release my health care provider from all responsibility and/or liability arising from the release of this confidential medical information.

I understand that this release expires 90 days from the date I sign it, and that any information obtained by my health care provider after this release expires will not be disclosed unless I sign a new authorization.

_____

APPLICANT'S PRINTED NAME APPLICANT'S SIGNATURE REQUIRED

TO THE PHYSICIAN: Forever Families requests a medical report on _____, an adoptive applicant to our agency. Our primary responsibility is to the children we are placing into new families. We need your confidential, objective opinion about the physical and mental health of the above named applicant, especially in relation to his/her fitness to raise a child/children. Although information from your past records is acceptable, we require this opinion to be based on a complete history recorded within the **last calendar year**. On behalf of the many children we serve, we thank you for the following candid, confidential report.

MEDICAL HISTORY

1. How long have you known the applicant? _____
2. Is the current report based on: Current examination only. _____
   Longer professional relationship and knowledge. _____
3. Please list current active medical diagnosis and treatments. Are the treatments adequate and disease controlled?

DIAGNOSIS	TREATMENT	CONTROL
a.		
b.		
c.		

   Past medical history: List ALL major surgeries, hospitalizations, sanitarium or institutional treatments or observations, chronic conditions, etc.

YEAR	CONDITIONS	CURRENT STATUS
a.		
b.		
c.		

4. List all knowledge of excessive alcohol use, alcoholism, drug abuse, arrest or convictions for DUI or treatments for same. Please explain.
   _____
   _____

5. List all knowledge of mental or emotional illness and treatment.
   _____
   _____
6. List all knowledge of past child abuse or neglect, or sexual abuse by applicant.
   _____
   _____
7. List all knowledge of physical, mental or emotional handicaps.
   _____
   _____
8. Can you add anything related to personality, physical or mental conditions or past health history not already explained which would affect the applicant's ability to parent a child?
   _____
   _____

CURRENT PHYSICAL EXAMINATION (explain all abnormal findings below)
Date of exam_____ General appearance _____

Height _____ Weight _____ BP _____ ☐ Within normal limits ☐ Abnormal

Explain _____

LABORATORY

No other tests are routinely required unless necessary to determine applicant's life expectancy.

SYNOPSIS

1. In your opinion, does the applicant have a normal life expectancy? _____
2. Please list any further referrals or consultations you would recommend regarding this applicant.
   _____
3. Please give your assessment of the applicant's ability to take proper care of a child or children.
   _____
4. If you would like a social worker to contact you to discuss this applicant's suitability for adoption, please indicate. _____ YES, Please call me.

PHYSICIAN'S CERTIFICATION

I certify that the above information was obtained by performing a history and physical examination within 12 months prior to _____ (today's date).
I do ☐/do not ☐ give permission for the information in this report to be shared with the applicant's family.

To the extent that this report contains information regarding sexually transmitted diseases and/or HIV/AIDS, this information has been disclosed to you from confidential records which may be protected by state law. State law may prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Physician's Signature _____ Phone (___)_____

Print Name _____ License # _____

Address _____