MEDICAL REPORT FOR HOUSEHOLD MEMBERS

State Form 45144 (R3 / 1-11)
DEPARTMENT OF CHILD SERVICES

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

Applicable program *(check one)*: ☐ Foster home ☐ Adoptive home	
Name	Date of birth *(month, day, year)*
Address *(number and street, city, state, and ZIP code)*	

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? ☐ Yes ☐ No	*If no, please provide the following information regarding the primary care physician.*
Name of primary care physician	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	

GENERAL HEALTH			
Blood pressure	Date of last medical examination *(month, day, year)*	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? ☐ Yes ☐ No

If yes, please explain.

Have you referred this person to a drug and alcohol assessment or screen? ☐ Yes ☐ No

If yes, please explain.

Name of physician referred to	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	

COMMUNICABLE DISEASES

Is this person free from communicable or contagious disease (initial appropriate response)? ☐ Yes ☐ No

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