LUTHERAN FAMILY SERVICES

GENERAL PHYSICAL EXAMINATION FOR A FOSTER CARE AND/OR ADOPTIVE APPLICANT

TO EXAMINING PHYSICIAN:

The applicant's permission for releasing information is given below. In evaluating the applicant, this agency must be guided by your medical findings, as reported on this form. It is necessary to determine that the applicant has no communicable diseases, has a reasonable life expectancy, and is capable both physically and emotionally, of carrying out the responsibilities of parenthood.

Please mail the completed form(s) in an envelope marked "CONFIDENTIAL" to:

Lutheran Family Services

Attention: _____

Address: _____

_____

PLEASE TYPE OR PRINT:

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

I hereby give my permission for release of this document to Lutheran Family Services.

_____

(Signature of Applicant)

PATIENT'S NAME: _____ BIRTHDATE_____

History of Major Illnesses and Hospitalizations: _____

_____

_____

_____

_____

_____

PHYSICAL EXAMINATION:

Date of this Examination: _____

Unless a shorter timeframe is indicated here, the next health evaluation will be required in two years.

_____
Alternate Date

Is patient under treatment for chronic illness: ☐Yes ☐No

If yes, what medications are prescribed? _____

What is the diagnosis? _____

What is the prognosis? _____

_____

_____

Are there any factors related to the patient's physical condition that would affect and/or prevent his/her ability to provide foster care or adoption? ☐Yes ☐No

If yes, describe:

_____

_____

_____

In your opinion, does the patient exhibit an emotional or psychological condition which would have a negative impact on the care of foster children? ☐Yes ☐No

If yes, describe:

_____

_____

_____

_____
Signature of Examining Physician

_____
Date of Report