MEDICAL STATEMENT FOR FOSTER CARE/ADOPTIVE APPLICANT AND ALL HOUSEHOLD MEMBERS

Name (LAST, FIRST, MIDDLE) Date of Birth

Address (Street, City, State and ZIP)

1. Have you had treatment for a serious or chronic illness? ☐ YES ☐ NO

   Have you been hospitalized in the past five years? ☐ YES ☐ NO

   Have you received, or been advised to seek, mental health services? ☐ YES ☐ NO

   Have you received, or been advised to seek, treatment for alcohol/substance abuse? ☐ YES ☐ NO

   If the answer to any of these questions is yes, please explain: _____

   _____

2. Have you or your parents, grandparents, or siblings had any of the following?
   (Check all that apply and indicate whom)

   ☐ Arthritis _____ ☐ Heart Disease _____

   ☐ Asthma _____ ☐ Hypertension _____

   ☐ Cancer _____ ☐ Kidney Disease _____

   ☐ Epilepsy _____ ☐ Tuberculosis _____

   ☐ Diabetes _____ ☐ Ulcers _____

   If any are checked, please explain: _____

   _____

3. Is there a history of other hereditary disease ☐ YES ☐ NO

   If yes, please explain: _____

   _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing the reverse side of this form to release any information he/she may have concerning my physical or mental health to:

_____
(Name of Agency)

_____ _____
Signature of Applicant Date

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION.

MEDICAL STATEMENT FOR FOSTER CARE/ADOPTIVE APPLICANT AND ALL HOUSEHOLD MEMBERS (Continued)

(This side of form to be completed by a licensed physician)

Date you last completed a physical examination of this individual: _____

Date you last treated this individual: _____

Do you provide medical services to this individual: ☐ Regularly ☐ Occasionally ☐ First Time

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

1. Does this individual suffer from an illness, including a communicable disease, that would be detrimental to the care of a foster/adoptive child placed in his/her home? ☐ YES ☐ NO
2. Are there any chronic or serious disorders for which this individual has received treatment? ☐ YES ☐ NO
3. Is this individual currently taking medication? ☐ YES ☐ NO
4. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster/adoptive child placed in his/her home? ☐ YES ☐ NO
5. Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? ☐ YES ☐ NO

If the answer to any of the above questions is YES, please explain: _____

(For foster/adoptive applicant only, please complete.)

Please state your professional opinion regarding this individual's suitability as a foster/adoptive parent from the standpoint of health, considering the individual's medical history as given on the reverse side of this form and from knowledge you have of the individual.

Physician's Signature Date

Physician's Work Address

Name of Physician (Print or Type)

City, State, ZIP Code

Physician's State License Number

Phone Number

NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rules 5101:2-5-20 or 5101:2-48-07.