



# MEDICAL REPORT FOR HOUSEHOLD MEMBERS

State Form 45144 (R4 / 11-15)  
DEPARTMENT OF CHILD SERVICES

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

Applicable program ( <i>check one</i> ):	
<input type="checkbox"/> Foster home	<input type="checkbox"/> Adoptive home
Name	Date of birth ( <i>month, day, year</i> )
Address ( <i>number and street, city, state, and ZIP code</i> )	

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?	<i>If no, please provide the following information regarding the primary care physician.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of primary care physician	Telephone number (    )
Address ( <i>number and street, city, state, and ZIP code</i> )	

GENERAL HEALTH			
Blood pressure	Date of last medical examination ( <i>month, day, year</i> )	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.
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In your professional opinion, do you believe it is necessary to request a drug and alcohol assessment or screen for this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please explain.
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Have you referred this person to a drug and alcohol assessment or screen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please explain.
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Name of physician referred to	Telephone number (    )
Address ( <i>number and street, city, state, and ZIP code</i> )	

COMMUNICABLE DISEASES	
Is this person free from communicable or contagious disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If this report is for a child, are immunizations current?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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