GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES
Prospective Foster or Adoptive Parent Medical Evaluation Report

Name of Person Examined: _____ **Exam Date:** _____

Date of Report: _____ **Date of Birth:** _____

The Medical Evaluation Report is used as a component of the foster and adoptive caregiver approval process. It is used to ascertain a medical opinion on the caregiver's physical wellness and capabilities as it relates to the care of children. This includes problems, conditions, and medication use that may affect his/her ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and in the foreseeable future (five to ten years).

A tuberculosis (TB) test is a required evaluation component. It may be conducted via skin or blood test.

The report must be completed and signed by a licensed physician, physician's assistant or public health department.

HEIGHT	WEIGHT	TEMPERATURE	PULSE	BLOOD PRESSURE (Indicate if Normal
Tuberculin (TB) Test Type ☐ Skin Test ☐ Blood Test		**Tuberculin (TB) Test Results** ☐ Positive ☐ Negative		
Is a follow-up TB test required? ☐ No ☐ Yes, please explain				

PHYSICAL EXAMINATION

Were the physical exam results within normal limits? ☐ Yes ☐ No (If no, explain):

_____

_____

HEALTH HISTORY

1. Is the patient currently diagnosed with any disorders related to the following? ☐ No ☐ Yes (If yes, check any that apply)

☐ Heart Problems	☐ Arthritis	☐ Depression	☐ Mental Illness
☐ Lung Problems	☐ Obesity	☐ Sleep Disorder	☐ Hepatitis
☐ Diabetes	☐ Malingering	☐ Cognition / Memory	☐ Allergies
☐ High Blood Pressure	☐ Dementia	☐ Kidney Disease	☐ Other
☐ Asthma	☐ Vision	☐ Epilepsy/Seizures	
☐ Hearing	☐ Strokes/Paralysis		

Please explain any items checked: _____

_____

_____

2. Is the patient prescribed any medications that impact their alertness, endurance or performance of tasks related to the care of children?

☐ No ☐ Yes (If yes, explain)

_____

_____

3. Does the patient have any history of substance abuse? ☐ No ☐ Yes (If yes, please check appropriate box(es) and describe)

☐ Alcohol _____ ☐ Prescription Drugs _____

☐ Other Drugs _____ ☐ Other Substance _____

4. Does the caregiver smoke any form of tobacco? ☐ No ☐ Yes

PHYSICAL CAPABILITIES

1. Does the patient have any physical limitations as it relates to the following?
   a) Lifting a child age 0 – 3 years old ☐ Yes ☐ No
   b) Walking/maneuvering without major difficulties ☐ Yes ☐ No
   c) Bending/stooping, knelling, reaching: ☐ Yes ☐ No
   d) Is an assistive device needed to walk, bend/stoop, kneel, or reach? ☐ No ☐ Yes (If yes, please explain)
   _____

2. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to lift from a bed to chair, frequent feedings, suctioning or administering medications? ☐ Yes ☐ No ☐ Don't Know

If yes, please explain: _____

PHYSICIAN'S CERTIFICATION

Approximately how long has the caregiver been a patient with your practice? _____

Were there any findings that would affect caring for a child now or in the foreseeable future, including any terminal illness?
☐ No ☐ Yes (If yes, explain):

_____

_____

Does the patient have any diagnosed medical conditions that require on-going appointments (other than an annual physical)?
☐ No ☐ Yes (If yes, explain):

_____

_____

Does the patient have any diagnosed medical condition that may impact their ability to care for children? ☐ No ☐ Yes (If yes, explain):

_____

_____

Were there any results found in the medical examination not reported elsewhere that would have an impact on the care of children?
☐ No ☐ Yes (If yes, explain)

_____

_____

Was the patient found to be free from symptoms of communicable disease? ☐ Yes ☐ No (If no, explain)

_____

Was the patient found to be free of physical or cognitive limitations that would impact child caregiving responsibilities?
☐ Yes ☐ No (If no, explain)

_____

Physician's Name: _____ State License Number: _____

Signature: _____ Date: _____

Office Name: _____

Address: _____

City, State, Zip _____