GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES
Other Household Member Medical Evaluation Report

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

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

The Medical Evaluation Report for household members other than the prospective parent(s) is used as a component of the foster and adoptive caregiver approval process. It is used to ascertain a medical opinion on the household member's wellness as it relates to communicable disease and overall health.

A tuberculosis (TB) test is a required evaluation component if the patient is age 18 years or older. 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 *(Required only if the patient is age 18 years or older)*		**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 being treated for any medical condition that is chronic or communicable? ☐ No ☐ Yes (If yes, please explain)

_____

2. If the patient is under age 18 years, are there immunizations current? ☐ No ☐ Yes (If no, 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 patient smoke any form of tobacco? ☐ No ☐ Yes

PHYSICIAN'S CERTIFICATION

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

Does the patient have any medical condition(s) that require(s) on-going appointments (other than an annual physical)? ☐ 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 in good health overall? ☐ Yes ☐ No (If no, explain)

_____

Physician's Name: _____ State License Number: _____

Signature: _____ Date: _____

Office Name: _____

Address: _____

City, State, Zip _____