Additional Household Member Medical Evaluation Report (CPA)

Name of Person Examined: _____ Exam Date: _____

Date of Birth: _____ Date of Report: _____

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.

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

Height: _____ Weight: _____ Temperature: _____ Pulse: _____ Blood Pressure: _____

Is Blood Pressure normal?

☐ Yes ☐ No

For Household Members 16 year or older only:

Tuberculin (TB) Test Type ☐ Skin Test ☐ Blood Test ☐ Chest X-Ray

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, are their immunizations current? ☐ No ☐ Yes
(If no, please explain): Please attach Certificate of Immunization (form 3231)

_____

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

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 be in good health overall? ☐ Yes ☐ No (If no, explain):

_____

Medical Personnel's Information

Licensed Physician's Name: _____ State License Number: _____

Physician's Assistant Name: _____

Public Health Personnel's Name: _____

Signature: _____ Date: _____

Office Name: _____

Address: _____

City, State, Zip Code: _____