GEORGIA DIVISION OF FAMILY & CHILDREN SERVICES

Additional Household Member Medical Evaluation Report

Name of Person Examined: _____ Exam Date: _____

Date of Birth: _____ Date of Report: _____

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: _____

Tuberculin (TB) Test Type ☐ Skin Test ☐ Blood Test

Is Blood Pressure normal? ☐ Yes ☐ No

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

Other, or please explain any items checked: _____

Prospective Foster or Adoptive Parent Medical Evaluation Report

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 year sold ☐ 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? ☐ Yes ☐ No (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: _____

_____

Prospective Foster or Adoptive Parent Medical Evaluation Report

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) _____

_____

Prospective Foster or Adoptive Parent Medical Evaluation Report

Physician's Name: _____ State License Number: _____

Signature: _____ Date: _____

Office Name: _____

Address: _____

City, State, Zip Code: _____