GEORGIA DEPARTMENT OF HUMAN RESOURCES

Medical Evaluation of an Adult in a Foster or Adoptive Home

Name of Person Examined: ____ Date: __________________

Date of Birth: _____________________________________ ☐ Foster Care Applicant ☐ Adoption Applicant

This form will aid the Department in determining the physical wellness and capabilities of foster and/or adoptive parents who are or may be caring for children. Please complete the following summary of health 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 for the foreseeable future (five to ten years).

I. HISTORY

1. Check any health problems:

☐ Heart Problems
☐ Lung Problems
☐ Diabetes
☐ High Blood Pressure
☐ Asthma
☐ Kidney Disease
☐ Arthritis
☐ Obesity
☐ Poor Ambulation
☐ Weak/Frail
☐ Vision
☐ Hearing
☐ Depression
☐ Sleep Disorder
☐ Confusion
☐ Dementia
☐ Epilepsy/Seizures
☐ Strokes/Paralysis
☐ Mental Illness
☐ Hepatitis
☐ Allergies
☐ Other

Explain ***all*** medical condition(s) checked and any other chronic conditions:

____

____

2. Are there any condition(s) that are progressive in nature? Yes ☐ No ☐
If yes, explain: ____

____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next ___5 years, ___10 years ___15 years? If yes, explain: ______________________________

____

4. Medication(s): ____

____

____

Are there any physical limitations as a result of medication(s)? Yes ☐ No ☐
If yes, explain: ____

____

5. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

6. Health Habits
Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol ☐ ____________________ Drugs ☐ ____________________
Tobacco ☐ ____________________ Other ☐ ____________________

II. PHYSICAL EXAMINATION

HEIGHT	WEIGHT	TEMPERATURE	PULSE	BLOOD PRESSURE (INDICATE IF NORMAL)

HEART		LUNGS (INCLUDING TUBERCULIN (TB) SKIN TEST OR CHEST X-RAY RESULTS)	
EYES		VISION	
EARS		NOSE/THROAT	
TEETH/GUMS		ABDOMEN	
ENDOCRINE		PELVIS	
NERVOUS SYSTEM		EXTREMITIES	
CURRENT LABORATORY RESULTS:			
URINALYSIS: SPECIFIC GRAVITY		ALBUMIN	
MICROSCOPIC		GLUCOSE	
OTHER LABORATORY TEST (NAME, DATE AND RESULTS)			

Summary of abnormal physical findings that would affect caring for a child:

____

____

____

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

1. Lift a child:
   Under 6 months Yes ☐ No ☐
   6 months to 3 years Yes ☐ No ☐

2. Walk/maneuver 50-100 feet without major difficulties: Yes ☐ No ☐

3. Bend/stoop, kneel, reach: Yes ☐
   No ☐

4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes ☐ No ☐
   If Yes, what type? ______________________________

5. 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, etc.	Yes ☐	No ☐	Don't Know ☐
Frequent Feedings	Yes ☐	No ☐	Don't Know ☐
Frequent Suctions	Yes ☐	No ☐	Don't Know ☐
Frequent Monitoring	Yes ☐	No ☐	Don't Know ☐
Frequent Medication	Yes ☐	No ☐	Don't Know ☐
Frequent Nebulizations	Yes ☐	No ☐	Don't Know ☐
Frequent Treatments	Yes ☐	No ☐	Don't Know ☐

Are any limiting conditions temporary? Yes ☐ No ☐
If yes, which condition(s): ______________________________
For each condition, how long will the limitation exist? ______________________________

IV. CERTIFICATION/SIGNATURE

I certify that this individual is found free from symptoms of communicable disease.
Yes ☐ No ☐ If No, explain: ______________________________

____

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.
Yes ☐ No ☐ If No, explain: ______________________________

____

☐ With appropriate signed releases, I am available to discuss this report.

Physician's Signature: ______________________ Date: ______________

State License Number: ______________________ Telephone: ______________

Address: ______________________________