DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CHILDREN'S ADMINISTRATION

# Applicant Medical Report - CONFIDENTIAL

| DATE |
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| |

**Section 1: Completed by Applicant and sent to Medical Provider**

| MEDICAL PROVIDER | PHONE NUMBER (AREA CODE) | | RETURN TO CA WORKER<br>**A Place Called Hope**<br>**5720 144th St NW, Suite 123**<br>**Gig Harbor, WA 98332**<br>**Ph: 253-857-5447 / Fax: 253-857-0710** |
|---|---|---|---|
| ADDRESS | | | |
| CITY | STATE | ZIP CODE | |

| NAME OF APPLICANT | DATE OF BIRTH |
|---|---|
| | |

I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have initialed below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from date of my signature. **NOTE: Be sure to initial each line and sign.**

____ mental illness, ____ alcohol and drug concerns, ____ sexual and/or physical abuse, ____ domestic violence.

SIGNATURE OF APPLICANT ______________________ DATE ____________

**Section 2: Completed by Medical Provider and sent to CA Worker Return Address above**

| DATE FIRST SEEN BY PROVIDER | | DATE OF LAST PHYSICAL EXAMINATION |
|---|---|---|
| DATE OF RESULTS OF LAST TB TEST | DATE OF LAST TDAP | DATE OF LAST INFLUENZA VACCINE |
| SPECIALIST REFERRED TO | ADDRESS OF SPECIALIST | |

REASON FOR REFERRAL

SIGNIFICANT PAST MEDICAL HISTORY INCLUDING CHRONIC / FREQUENT MEDICAL ISSUES

CURRENT MEDICAL DIAGNOSIS

CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN, AND HOW IT AFFECTS DAILY FUNCTIONING.

PROGNOSIS

PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF CHILDREN.

COMMENTS OR IMPRESSIONS

| MEDICAL PROVIDER'S SIGNATURE | DATE |
|---|---|
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