WASHINGTON STATE Department of Children, Youth, and Families

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES
LICENSING DIVISION (LD)

Applicant Medical Report - CONFIDENTIAL

DATE

Section 1: Completed by Applicant and sent to Medical Provider

MEDICAL PROVIDER	PHONE NUMBER (AREA CODE)		RETURN TO CASE WORKER
			A Place Called Hope
ADDRESS			**P.O. Box 10**
			Burley, WA 98335
CITY	STATE	ZIP CODE	**Phone 253-857-5447**
			FAX 253-857-0710

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 case worker Return Address above

DATE FIRST SEEN BY PROVIDER		DATE OF LAST PHYSICAL EXAMINATION
DATE **AND** 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