South Carolina Department of Social Services

MEDICAL REPORT FOR ADULT HOUSEHOLD MEMBERS

Name of Person Examined:_____Birthdate:_____

Relationship to Applicant:_____

I hereby authorize_____to release the medical information contained on this form
Licensed Medical Practitioner

to SC DSS.

Patient's Signature:_____Date: _____

To the Examining Licensed Medical Practitioner: This report will provide SCDSS the health of all adult household members of a prospective foster/adoptive family and to assess the entire household's ability to care for a child.

Physical Examination:

Height:_____Weight:_____Blood Pressure: _____

Eyes: _____ Ear, Nose, Throat:_____Heart:_____

Lungs: _____ Date of Examination: _____

Does the patient have any contagious or communicable diseases? If so, please describe.

Does the patient have any health concerns that would affect or limit his or her or the family's ability to care for a child or cause concern for the safety and well-being of a child if placed within the home? If so, please describe.

Current medications and reason prescribed

	Medication	Reason Prescribed
1.		
2.		
3.		
4.		
5.		

Has the patient had an annual flu shot? ___yes ____no if yes, date given:_____
Has the patient been vaccinated for whooping cough in the last 10 years? ___yes ___no if yes, date given:_____

Licensed Medical Practitioner's Printed Name: _____

Licensed Medical Practitioner's Signature:_____Date:_____

Address: _____

_____

Phone: _____