DIAKON ADOPTION & FOSTER CARE
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Resource Parent Medical Report

Our client has come to you in response to a request from this agency for a report on his/her physical condition. It is important for us to know of any health factors or communicable diseases, which may interfere with his/her ability to care for a child.

I. GENERAL INFORMATION

PATIENT NAME:		**DATE OF BIRTH:**	**SEX:**
HEIGHT:	**WEIGHT:**	**BLOOD PRESSURE:**	
TB TEST DATE:	**TB TEST READ DATE:**	**TB TEST RESULTS (MM):**	

II. SIGNIFICANT MEDICAL CONDITIONS OF PATIENT (*Please check yes or no for each)

YES	NO	CONDITION	If yes, explain and list medication taken for the condition
☐	☐	Alcohol	
☐	☐	Allergies	
☐	☐	Arthritis	
☐	☐	Asthma	
☐	☐	Cancer	
☐	☐	Chemical Dependency	
☐	☐	Cigarette	
☐	☐	Cholesterol	
☐	☐	Chronic Pain/fatigue	
☐	☐	Communicable/Infectious Diseases	
☐	☐	Drugs – other	
☐	☐	Diabetes	
☐	☐	Digestive Disorder	
☐	☐	Epilepsy	
☐	☐	Hearing Impairment	
☐	☐	Heart Ailment	
☐	☐	Hepatitis	
☐	☐	Hypertension	
☐	☐	Mental Illness	
☐	☐	Depression	
☐	☐	Bi-polar	
☐	☐	Schizophrenia	
☐	☐	Anxiety	
☐	☐	Psychiatric Hospitalization	
☐	☐	Migraine Headaches	

☐	☐	Musculoskeletal Disorder	
☐	☐	Neuromuscular Disorder	
☐	☐	Orthopedic Condition	
☐	☐	Renal Illness	
☐	☐	Respiratory Illness	
☐	☐	Seizure Disorder	
☐	☐	Skin Disorder	
☐	☐	Thyroid	
☐	☐	Vision Impairment	
☐	☐	Other:	

III. Please list any medications *(prescription or over-the-counter)* NOT LISTED ABOVE that the patient is currently taking or prescribed and for what purpose:

IV. Based on your evaluation:

- **Do you feel this patient is free of any physical condition that might unfavorably affect a foster or adoptive child?**

- **Is this patient free from Communicable/Infectious disease? Yes ☐ No ☐ If no, explain:**

- **What is the patient's prognosis for continued health?**

- **Do you feel this patient is mentally competent to parent a child or do you feel further mental health or psychological evaluations are necessary for you to make the aforementioned determination? **Please provide recommendation as to any follow up or additional testing you find necessary.***

EXAMINING PRACTITIONER'S SIGNATURE:
EXAMINING PRACTITIONER'S PRINTED NAME:
NAME OF PRACTICE: **DATE OF EXAM:**
ADDRESS OF PRACTICE:
TELEPHONE NUMBER:

FORM UPDATED 9-21-2016