Reset Form

Ohio Department of Job and Family Services

# MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT AND ALL HOUSEHOLD MEMBERS

## Section I - For all applicants and household members.

| Name (*LAST, FIRST, MIDDLE*) | Date of Birth |
|---|---|
| Address (*Street, City, State and ZIP*) | |

1. Have you had treatment for a serious or chronic illness? ☐ Yes ☐ No

   Have you been hospitalized in the past five years? ☐ Yes ☐ No

   Have you ever received, or been advised to seek, mental health services? ☐ Yes ☐ No

   Have you ever received, or been advised to seek, treatment for alcohol or substance abuse? ☐ Yes ☐ No

   If any are checked, please explain: _____

   _____

2. Have you or your parents, grandparents, or siblings had any of the following? (*Check all that apply and indicate whom*)

   ☐ Arthritis _____
   ☐ Asthma _____
   ☐ Cancer _____
   ☐ Epilepsy _____
   ☐ Diabetes _____
   ☐ Heart Disease _____
   ☐ Hypertension _____
   ☐ Kidney Disease _____
   ☐ Tuberculosis _____
   ☐ Ulcers _____

   If any are checked, please explain: _____ _____

   _____

3. Is there a history of other hereditary disease? ☐ Yes ☐ No

   If yes, please explain: _____

| **Attach an official copy of the individual's immunization record as applicable to the requirement of childhood immunizations (children living in the home), pertussis immunizations (everyone in home caring for infants), or annual flu immunization (everyone in home caring for infants and any age child with medical needs).** |
|---|
| There are exemptions available to the immunization requirements pursuant to rule 5101:2-5-20. Please list all required immunizations which the person listed above has not received and whether it is medically contraindicated, medically inappropriate, or declined by the individual/parent. |
| ☐ I have declined immunizations for the person listed at the top of this form for reasons of conscience, including religious reasons. |
| ☐ N/A – Adoption Homestudy Only |

| I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. | |
|---|---|
| Signature of applicant, household member or parent/legal guardian | Date |

## Section II - For applicants only.

| Date you completed the physical examination of this individual | Date you last treated this individual |
|---|---|
| | |

Do you provide services to this individual?

☐ Regularly ☐ Occasionally ☐ First Time

Please respond to each of the following to the best of your knowledge:

1. Does this individual suffer from an illness, including a communicable disease, that would be detrimental to the care of a foster/adoptive child placed in his/her home? ☐ Yes ☐ No

2. Are there any chronic or serious disorders for which this individual has received treatment? ☐ Yes ☐ No

3. Is this individual currently taking medication? ☐ Yes ☐ No

4. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster/adoptive child placed in his/her home? ☐ Yes ☐ No

5. Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? ☐ Yes ☐ No

If the answer to any of the above questions is YES, please explain: _____

_____

**(For foster/adoptive applicant only, please complete)**

Please state your professional opinion regarding this individual's suitability as a foster/adoptive parent from the standpoint of health, considering the individual's medical history as given on the reverse side of this form and from knowledge you have of the individual. _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing this form to release any information he/she may have concerning my physical or mental health to:

_____

(*Name of Agency*)

| Signature of Applicant | Date |
|---|---|
| | |

| Signature | Date | Name *(Print or Type)* | |
|---|---|---|---|
| | | | |
| Please check one of the following:<br>☐ Licensed Physician ☐ Physician Assistant<br>☐ Clinical Nurse Specialist ☐ Certified Nurse Practitioner<br>☐ Certified Nurse-Midwife | | Work Address | |
| | | Work Phone Number | State License Number |

**NOTE: Completion of this form is required by Chapter 5101:2-5 and Chapter 5101:2-48 of the Ohio Administrative Code.**