

AAA Partners In Adoption, Inc.

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Executive Director

MEDICAL REPORT FOR ADOPTIVE APPLICANT

Name of Person Examined: _____ Date: _____
(Last) (First) (Middle)

Date of Birth: _____

Please complete the following summary of health problems, conditions, and medication use that may effect his/her ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with care for child(ren), ages 0-18, now and for the foreseeable future (five to ten years).

I. HISTORY

1. Check any health problems:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Obesity | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Poor Ambulation | <input type="checkbox"/> Confusion | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weak/Frail | <input type="checkbox"/> Dementia | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Vision | <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing | <input type="checkbox"/> Strokes/Paralysis | |

Explain *all* medical condition(s) checked and any other chronic conditions:

2. Are there any condition(s) that are progressive in nature? Yes No

If yes, explain: _____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next 5 years, 10 years, 15 years? If yes, explain:

4. Medication(s):

Are there any physical limitations as a result of medication(s)? Yes No If yes, explain:

5. Illnesses/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

6. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

- Alcohol _____
- Drugs _____
- Tobacco _____
- Other _____

II. PHYSICAL EXAMINATION

HEIGHT	WEIGHT	TEMPERATURE	PULSE	BLOOD PRESSURE - INDICATE IF NORMAL	
HEART			LUNGS (INCLUDING TUBERCULIN (TB) SKIN TEST OR CHEST X-RAY RESULTS)		
EYES			VISION		
EARS			NOSE / THROAT		
TEETH / GUMS			ABDOMEN		
ENDOCRINE			PELVIS		
NERVOUS SYSTEM			PAP SMEAR		
RPR TEST			EXTREMITIES		
DRUG SCREEN					
CURRENT LABORATORY RESULTS:					
URINALYSIS: SPECIFIC GRAVITY			ALBUMIN		
MICROSCOPIC			GLUCOSE		
OTHER LABORATORY TEST (NAME, DATE AND RESULTS)					

Summary of abnormal physical findings that would affect caring for a child:

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

1. Lift a child:

Under 6 months Yes No

6 months to 3 years Yes No

2. Walk/maneuver 50-100 feet without major difficulties: Yes No

3. Bend/stoop, kneel, reach:

No

4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes No

If Yes, what type? _____

5. Are there any medical conditions which might limit this person's physical ability to care for a medically complex child which may include the ability to:

Lift from a bed to a chair, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Frequent Feedings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Frequent Suctions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Frequent Monitoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Frequent Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Frequent Nebulizations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Frequent Treatments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know

Are any limiting conditions temporary? Yes No

If Yes, which condition(s): _____

For each condition, how long will the limitation exist? _____

IV. CERTIFICATION / SIGNATURE

I certify that this individual is found free from symptoms of communicable disease.

Yes No If No, explain: _____

I certify that the individual has no physical or cognitive limitations that would prevent him/her from parenting.

Yes No If No, explain: _____

- o With appropriate signed releases, I am available to discuss this report.

Physician's Signature: _____ Date: _____

State License Number: _____ Telephone: _____

Address: _____