FOR FILING PURPOSES
NAME OF APPLICANT:
AGENCY NAME:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

ADOPTIVE APPLICANT MEDICAL REPORT (PART ONE)

ADOPTION ONLY

Instructions:

Applicant: There are three sections to this form. **Section 1** is to be completed by the applicant. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for the applicant.

Home finder/agency worker: Complete **Section 2** before providing the form to the applicant. Provide one form per applicant.

SECTION 1: APPLICANT INFORMATION		
NAME OF APPLICANT:		
LAST, FIRST, MIDDLE INITIAL:	DATE OF BIRTH: / /	TELEPHONE NUMBER: ( ) -
ADDRESS OF APPLICANT:		
I hereby request and authorize my physician to release the following information to the agency named below.		
APPLICANT'S SIGNATURE **X**	DATE: / /	
The above-named applicant has applied to adopt a child. Per New York State regulations, the agency is required to obtain a medical report regarding the members of the household's general health. Such report must show that each member of the household is free from communicable disease, infection or illness or any physical or mental condition(s) which might affect the proper care of an adopted child. Such report must cover a physical examination of the applicant conducted not more than one year preceding the date the application for approval is submitted to the agency.		

SECTION 2: AGENCY INFORMATION
AGENCY NAME:
AGENCY ADDRESS:
AGENCY CONTACT: (Home Finder's/Agency Worker's Name and Phone Number)

SECTION 3: To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each applicant.	
Please respond to each of the following to the best of your knowledge:	
Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment?	☐ No ☐ Yes
Is this individual currently taking medications?	☐ No ☐ Yes
Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse?	☐ No ☐ Yes
Please provide an explanation for any "Yes" response.	

GENERAL HEALTH REVIEW OF APPLICANT			
PHYSICAL EXAM DATE: / /	HEIGHT: :	WEIGHT: LBS	BLOOD PRESSURE: /
VISION:		HEARING:	
CARDIOVASCULAR:		PULMONARY:	
GASTROINTESTINAL:		ENDOCRINE:	
NERVOUS SYSTEM:		MUSCULAR/SKELETAL:	
SKIN:			

FOR FILING PURPOSES
NAME OF APPLICANT:
AGENCY NAME:

Does the individual have any communicable disease, infection or illness, or any physical or mental condition that might affect the proper care of children? ☐ No ☐ Yes
Explain:

Does the presence of any identified affliction pose a risk to the health and safety of children? ☐ No ☐ Yes
Explain:

FINDINGS

On the basis of my findings, as indicated above, and my knowledge of the individual, I find the above-listed individual:
☐ **IS** ☐ **IS NOT** in such physical condition that it is reasonable to expect him/her to live to the child's majority and have the energy and other abilities needed to fulfill parental responsibilities.
If not:
Explain:

MEDICAL CARE PROVIDER'S SIGNATURE:	TELEPHONE NUMBER:	DATE SIGNED:
X	( ) -	/ /

PROVIDER'S ADDRESS:

PHYSICIAN'S STAMP:

MEDICAL CARE PROVIDER SHOULD RETURN COMPLETED REPORT TO AGENCY CONTACT LISTED IN SECTION 2.

FOR FILING PURPOSES
NAME OF APPLICANT:
AGENCY NAME:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

HOUSEHOLD MEMBER MEDICAL REPORT (PART TWO)

ADOPTION ONLY

Instructions:

Applicant(s): There are three sections to this form. **Section 1** is to be completed by the applicant if household member is under 18 years of age or by the household member if 18 years of age or older. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member.

Home finder/agency worker: Complete **Section 2** before providing the form to the applicant(s). Provide one form per applicant.

SECTION 1: HOUSEHOLD MEMBER INFORMATION		
LAST, FIRST, MIDDLE INITIAL:	DATE OF BIRTH: / /	TELEPHONE NUMBER: ( ) -
The above-named individual is residing in the home of an individual(s) who is seeking to adopt a child. Per New York State regulations, the agency is required to obtain a medical report regarding the members of the household's general health. Such report must show that each member of the household is free from communicable disease, infection or illness or any physical or mental condition(s) which might affect the proper care of an adopted child. Such report must cover a physical examination of the household member conducted not more than one year preceding the date the application for approval is submitted to the agency.		
NAME OF APPLICANT(S):	RELATIONSHIP TO APPLICANT(S):	
ADDRESS OF APPLICANT(S):		
I hereby request and authorize my physician to release the following information to the agency named below.		
HOUSEHOLD MEMBER OR PARENT/GUARDIAN IF HOUSEHOLD MEMBER IS UNDER 18 YEARS OF AGE SIGNATURE: **X**	DATE: / /	

SECTION 2: AGENCY INFORMATION
AGENCY NAME:
AGENCY ADDRESS:
AGENCY CONTACT: (Home Finder's/Agency Worker's Name and Phone Number)

SECTION 3: To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member of an applicant	
Please respond to each of the following to the best of your knowledge:	
Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment?	☐ No ☐ Yes
Is this individual currently taking medications?	☐ No ☐ Yes
Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse?	☐ No ☐ Yes
Does the individual have any communicable disease, infection or illness, or any physical or mental condition that might affect the proper care of children?	☐ No ☐ Yes
Does the presence of any identified affliction pose a risk to the health and safety of children?	☐ No ☐ Yes
Please provide an explanation for any "Yes" response.	
Is the above-listed individual in good physical and mental health, and free from communicable diseases, infection or illness?	☐ No ☐ Yes
Please provide an explanation for a "No" response.	

FOR FILING PURPOSES
NAME OF APPLICANT:
AGENCY NAME:

MEDICAL CARE PROVIDER'S SIGNATURE: **X**	TELEPHONE NUMBER: ( ) -	DATE SIGNED: / /
PROVIDER'S ADDRESS:		
PHYSICIAN'S STAMP:		

MEDICAL CARE PROVIDER SHOULD RETURN COMPLETED REPORT TO AGENCY CONTACT LISTED IN SECTION 2.