WIDE HORIZONS
FOR CHILDREN

Medical Statement

Instructions to Applicants:

- Please print or type
- Make a copy of this form for yourself and for each person who is living in your home.
- The shaded section listed immediately below must be completed before submission to a physician.
- Be sure that the physician has signed and dated the back of this form following the examination. Form should be returned to WHFC (by either patient or physician) after exam.
- Please be aware that additional medical information may be required depending on country choice. If you have already decided on the country you will be adopting from, please contact the country-specific program team in WHFC's Central Office for details.

Prospective Adoptive Parent(s) Name(s): _____

Patient's Name: _____ Date of Birth: _____

Patient's Relationship to Prospective Adoptive Parent(s): _____

Patient's Address: _____

Consent for release of information given by: _____ _____

(please print) *(please sign)*

Patient's Medical History

Physician, how long have you known this patient? _____

In what capacity? _____

Have any of the following conditions been present? If yes, please describe in space below and include pertinent dates.

- ☐ Allergies
- ☐ Asthma/Respiratory Condition
- ☐ Cancer
- ☐ Diabetes
- ☐ Infertility
- ☐ Motor Impairment
- ☐ Tuberculosis
- ☐ Surgeries
- ☐ Seizures
- ☐ Emotional Disorders
- ☐ Other Communicable Diseases

☐ Other Medical Conditions or Disabilities: _____

_____

_____

Have there been any miscarriages, still births or death of any children in this patient's immediate family? ☐ Yes ☐ No

If yes, please describe: _____

Has this person been hospitalized for any medical or emotional conditions during the past five years?

☐ Yes ☐ No

If yes, please list date, reason and diagnosis: _____

(continued on opposite side)

Physical Examination

Date of exam: _____ Height: _____ Weight: _____ BP: _____

Are there any abnormalities with any of the following? Please explain below:

☐ Heart ☐ Speech ☐ Hearing

☐ Lungs ☐ Nervous System ☐ Other _____

☐ Gastrointestinal Systems ☐ Vision

Is the patient free from communicable diseases? ☐ Yes ☐ No

Additional information required for New York State residents:

PPD Mantoux Skin Test: ☐ Negative ☐ Positive

If positive, chest x-ray is mandated. Chest x-ray results: _____

Please list any of the patient's current medical and/or emotional conditions: _____

_____

_____

Are there any medical/emotional conditions that would prevent this person from being a capable parent? _____

Please list any regularly prescribed medications: _____

_____

_____

Does the patient have a normal life expectancy? ☐ Yes ☐ No

If not, please explain: _____

_____

_____

Additional Information Required for Children

Is there any reason why this child's emotional development will be put at risk by the placement of a new child in the home? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Is the child up to date with all of his/her required inoculations? ☐ Yes ☐ No

If not, please list those still required: _____

_____

_____

Physician Name: _____ Physician Phone: _____

Physician Signature: _____ Date: _____

**Note: Signature indicates permission to share this information with the patient*

Please return to: Wide Horizons For Children, 144 Moody Street, Building 24, Second Floor, Waltham, MA 02453