Ohio Department of Job and Family Services

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

(FOSTER/ADOPTIVE PARENTS MUST COMPLETE THIS SIDE ONLY)

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

   If any are checked, please explain: _____

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

   If yes, please explain: _____

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 the reverse side of this form to release any information he/she may have concerning my physical or mental health to: **Summit County Children Services**
(Name of Agency)

Signature of Applicant	**Date**

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION

(THIS SIDE OF FORM TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL)

Date you last completed a 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: _____

_____

_____

_____

Medical Professional to complete: (For foster/adoptive applicant only)

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:

_____

_____

_____

MEDICAL PROFESSIONAL TO COMPLETE

Medical Professional Signature	Date	Medical Professional Name *(Print or Type)*	
Please Return completed form to:	**Please Check One of the following**	**Medical Professional Work Address:**	
	☐ Licensed Physician ☐ Clinical Nurse Specialist ☐ Certified Nurse-Midwife ☐ Physician Assistant ☐ Certified Nurse Practitioner		
Summit County Children Services 264 S. Arlington Street Akron, Ohio 44306-1354		**Work Phone Number:**	**State License Number:**

NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rule 5101:2-5-20 or 5101:2-48-07.