MEDICAL EXAMINATION OF APPLICANT(S)
(To be completed by a medical professional)

_____
(Name)

Height_____ Weight_____

Does this person have any illnesses that they are being treated for? _____
_____

Is this patient currently taking any medication? Yes or No

If yes, what medication? _____

Has patient experienced any of the following symptoms in the past year?

a) Productive couch for more than 3 weeks? Yes No
b) Coughing up blood? Yes No
c) Unexplained weight loss Yes No
d) Fever, chills, night sweats? Yes No

Contact with anyone with active TB in the past year? Yes No

e) Persistent short of breath? Yes No
f) Unexplained fatigue? Yes No
g) Chest Pain? Yes no

Is there any medical reason that this patient should not become an adoptive parent? Yes or No

If yes, please explain: _____

Is this person seeing treatment for any psychiatric problems that could affect their ability to be an adoptive parent? Yes or No

If yes, please explain_____

Date of report_____ Signed _____, MD/NP/PA

Please print name clearly _____

Address _____

Phone _____