The Children's Aid Home Programs of Somerset County, Inc.

1476 NORTH CENTER AVENUE ~ P.O. BOX 1195 SOMERSET, PA 15501

814.443.1637 ~ FAX 814.445.8481

MEDICAL REFERENCE INFORMATION

Applicant Name: ____

Address: ____

Phone No.: ____

MEDICAL HISTORY

Please list current medical condition(s) or special needs of patient and elaborate on them:______________

____

If health conditions are noted please give a statement about the patient's life expectancy and their ability to care for a child until the child is an adult:____

____

Height: _____________ Weight: ____________

Extremities: ____________ Eyes: ____________

Ears, Nose, Throat: __________ Genitourinary Tract: _____________

Lungs: ______________ Abdomen: ____________

How long have you known this patient: ______________________

Please list any regularly prescribed medications: ____

____

Significant Past Medical History? Please include condition, date and outcome/prognosis.

____

____

History of Infectious or Communicable Diseases? Please include condition, date and outcome/prognosis.____

____

Please give your opinion as to whether any physical health, mental health or emotional condition(s) would influence or impair this patient's ability to parent and/or adopt a child:

____

____

Over

Additional Comments: ____

____

This certifies that the above individual has no communicable diseases or physical conditions that might endanger the health and safety of children or prevent the person from performing the essential job functions relating to child care.

Physician's Signature: ____

Physician's Full Name (Print): ___________________________________

Exam Date: ____

License No.: ____

Address: ____

Phone No.: ____