

Ohio Department of Job and Family Services
**MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT
 AND ALL HOUSEHOLD MEMBERS**

Section I - For all applicants and household members.

Name (<i>LAST, FIRST, MIDDLE</i>)	Date of Birth
Address (<i>Street, City, State and ZIP</i>)	

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 or 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*)
- | | |
|--|--|
| <input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Ulcers _____ |
|--|--|

If any are checked, please explain: _____

3. Is there a history of other hereditary disease? Yes No
- If yes, please explain: _____

Attach an official copy of the individual's immunization record as applicable to the requirement of childhood immunizations (children living in the home), pertussis immunizations (everyone in home caring for infants), or annual flu immunization (everyone in home caring for infants and any age child with medical needs).

There are exemptions available to the immunization requirements pursuant to rule 5101:2-5-20. Please list all required immunizations which the person listed above has not received and whether it is medically contraindicated, medically inappropriate, or declined by the individual/parent.

I have declined immunizations for the person listed at the top of this form for reasons of conscience, including religious reasons.

I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct.

Signature of applicant, household member or parent/legal guardian	Date
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Section II - For applicants only.

Date you completed the physical examination of this individual	Date you last treated this individual
Do you provide services to this individual?	
<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> 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: _____

(For foster/adoptive applicant only, please complete)

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. _____

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 this form to release any information he/she may have concerning my physical or mental health to:	

<i>(Name of Agency)</i>	
Signature of Applicant	Date

Signature	Date	Name <i>(Print or Type)</i>	
Please check one of the following:		Work Address	
<input type="checkbox"/> Licensed Physician	<input type="checkbox"/> Physician Assistant		
<input type="checkbox"/> Clinical Nurse Specialist	<input type="checkbox"/> Certified Nurse Practitioner		
<input type="checkbox"/> Certified Nurse-Midwife			
		Work Phone Number	State License Number

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