Ohio Department of Children and Youth

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

Section I - For all applicants and household members.

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 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*)

- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Epilepsy _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Kidney Disease _____
- ☐ Tuberculosis _____
- ☐ 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 Ohio Administrative Code. 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

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?

☐ 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: _____

(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:

Adoption Home Study Services of Ohio
(*Name of Agency*)

Signature of Applicant	Date

Signature	Date	Name *(Print or Type)*	
Please check one of the following: ☐ Licensed Physician ☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Certified Nurse Practitioner ☐ Certified Nurse-Midwife		Work Address	
		Work Phone Number	State License Number

NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rules.

Ohio Department of Children and Youth

INSTRUCTIONS FOR COMPLETING DCY 01653, MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT AND ALL HOUSEHOLD MEMBERS

USING THIS FORM

• This form is used to determine the suitability of an applicant to be a foster caregiver or adoptive home.

SECTION I

• This section is to be completed for each applicant and each household member. Each individual or parent/legal guardian will complete the information and sign the form. No other signatures are necessary for this section.

SECTION II

• This section is only for applicants and not for household members. A physical exam is required and must be completed by a licensed physician, physician assistant, clinical nurse specialist, certified nurse practitioner, or certified nurse-midwife.