

Ohio Department of Job and Family Services  
**MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT  
 AND ALL 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/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 _____<br><input type="checkbox"/> Asthma _____<br><input type="checkbox"/> Cancer _____<br><input type="checkbox"/> Epilepsy _____<br><input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____<br><input type="checkbox"/> Hypertension _____<br><input type="checkbox"/> Kidney Disease _____<br><input type="checkbox"/> Tuberculosis _____<br><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: \_\_\_\_\_  
 \_\_\_\_\_

<b>AUTHORIZATION FOR RELEASE OF INFORMATION</b>	
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:	
_____ <i>(Name of Agency)</i>	
Signature of Applicant	Date

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

Date you last completed a 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: \_\_\_\_\_

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**(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. \_\_\_\_\_

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Signature	Date	Name ( <i>Print or Type</i> )	
Please check one of the following <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 Address	
		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.**