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|  | LICENSING DIVISION (LD)**Applicant Medical Report - CONFIDENTIAL** |  |
| DATE |
| **Section 1: Completed by applicant. Return to local Licensing Division office.**  |
| MEDICAL PROVIDER | PHONE AND FAX NUMBER (AREA CODE) | LOCAL LICENSING DIVISION OFFICE:**Fax to:Youthnet****Attn Foster Care(360)336-0165** |
| ADDRESS NAME/LOCATION  |
| CITY | STATE | ZIP CODE |
| NAME OF APPLICANT | DATE OF BIRTH |
| I hereby authorize my medical provider to release my medical history information including, but not limited to, information on the issues I have initialed below. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from the date of my signature. **NOTE: Be sure to initial each line and sign.** mental illness,  alcohol and drug concerns,  sexual and/or physical abuse,  domestic violence. |
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|  SIGNATURE OF APPLICANT DATE |
| **Section 2: Completed by Medical Provider. Return to local Licensing Division office listed above.**  |
| DATE OF MOST RECENT PHYSICAL EXAMINATION (**MUST BE WITHIN 12 MONTHS OF APPLICATION**) | DATE FIRST SEEN BY PROVIDER   |
| DATE OF LAST TB TEST  (FOR LICENSING ONLY) | RESULTS OF LAST TB TEST (FOR LICENSING ONLY) | DATE OF LAST TDAP | DATE OF LAST INFLUENZA VACCINE (FOR LICENSING ONLY) |
| SPECIALIST REFERRED TO | ADDRESS OF SPECIALIST |
| REASON FOR REFERRAL |

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| CHRONIC / FREQUENT MEDICAL ISSUES SIGNIFICANT PAST MEDICAL HISTORY INCLUDING |

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| CURRENT MEDICAL DIAGNOSIS |

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| CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, ANTICIPATED SIDE EFFECTS AND CONCERNS IF THE MEDICATION IS NOT TAKEN, AND HOW IT AFFECTS DAILY FUNCTIONING  |

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| PROGNOSIS |

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| PLEASE DESCRIBE HOW ANY MEDICAL CONDITION AFFECTS THE CARE OF ADDITIONAL CHILDREN |

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| COMMENTS/ IMPRESSIONS: IS THE APPLICANT CAPABLE OF CARING FOR AN ADDITIONAL CHILD OR CHILDREN? |

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| MEDICAL PROVIDER SIGNATURE  | PRINT NAME | DATE |