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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. | | | | | | | | | | |
|  |  | | | | | | | | |  |
| 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 |