MEDICAL EVALUATION FORM

Health Care Provider: _____	Date: _____
Name of Person Examined: _____	Date of Birth (dd/mm/yyyy): _____
Address of Patient: _____ _____	
This form will aid the For The Child (FTC) Foster Care Unit to determine the physical wellness and capabilities of foster parents who are, or may be, caring for children. Please complete the following summary of health issues and medication use that may affect his/her ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to four children, ages 0 to 17 years, currently and for the foreseeable future (five to ten years).	

Section A – Medical History

1. Please indicate, from the list below, all the health challenges faced by the patient:

Heart problems ☐	Hearing problems ☐	Depression ☐	Mental illness ☐
Lung problems ☐	Vision problems ☐	Sleep disorder ☐	Hepatitis ☐
Diabetes ☐	Weakness/Frailty ☐	Confusion ☐	Allergies ☐
Asthma ☐	Poor ambulation ☐	Dementia ☐	Other ☐
Hypertension ☐	Obesity ☐	Epilepsy/Seizures ☐	
Kidney disease ☐	Arthritis ☐	Strokes/Paralysis ☐	

Please explain all medical conditions checked and any other chronic conditions:

_____

_____

_____

2. Based on the condition(s) above, do you think there are health-related issues that may negatively impact this person's ability to care for a child? YES ☐ NO ☐

If yes, please explain: _____

_____

3. Medications being used:

_____

_____

Are there any physical limitations resulting from the use of medications? YES ☐ NO ☐

If yes, please explain: _____

_____

4. Please list any illnesses, injuries, operations or hospitalisations within the last 5 years:

Illness/ Injury	Hospitalisation	Operation	Date	Outcome

5. Is there any history of substance use by the patient? To what degree does the use of the substance impair his/her functioning?

Alcohol	
Drugs	
Tobacco	
Other _____	

Section B – Physical Examination

Height	Weight	Temperature	Pulse	Blood Pressure
				Normal? YES [ ] NO [ ]

Abdomen	
Ears	
Endocrine	
Eyes	
Lungs	
Nose	

Pelvis	
Teeth/Gums	
Throat	
Vision	
Nervous System	
Extremities	

Current Laboratory Results

Urinalysis: Specific Gravity	
Glucose	
Albumin	
Chest X-Ray Results (Physician's discretion)	
Other Laboratory Tests (Name, Date, Results)	

Summary of any abnormal physical findings that may affect caring for a child:

_____

_____

_____

_____

_____

_____

Section C – Physical Capabilities

PLEASE CHECK THE APPROPRIATE RESPONSE TO EACH OF THE FOLLOWING QUESTIONS.

In your medical opinion, is the patient physically able to:	YES	NO	DON'T KNOW
1. Lift a child a. Under 6 months old?			
b. 6 months to 3 years old?			
2. Walk/ manoeuvre 50-100 ft without major difficulties?			
3. Bend/stoop, kneel, reach?			
4. Is an assistive device needed to walk, bend/ stoop, kneel or reach? If yes, what type? _____			
5. Are there any medical conditions which would limit the patient's ability to care for a medically complex child which may include:			
a. Lifting from chair to bed, etc.			
b. Frequent feedings/suctions			
c. Frequent monitoring			
d. Frequent medication			
e. Frequent nebulisation			
f. Frequent treatments			
6. Are there any temporary physical limitations?			
If yes to 6, please explain: _____ _____ _____			

Section D – Certification

I, Dr _____ certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting: **YES** ☐

NO ☐ (Please explain) _____

_____

_____

With appropriate signed releases, I am available to discuss this report ☐

Physician's signature _____ Date: _____

Telephone _____ Email: _____

Business Address:

_____

_____

Section E – Patient's Authorisation

I _____ authorise Dr _____ to release my medical information to representatives of Family Life Ministries' For The Child Foster Care Programme as required by the programme.

_____	_____	_____	_____
Patient's signature	Date	Signature of Witness	Date