CommonSense
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CommonSenseAdoption.org

Adoption & Foster Care SERVICES

MEDICAL REFERENCE

(To be completed by applicant's treating physician)

Applicant Name:_____

1. What is your opinion concerning the **general health** of this patient? (Check one.)

   ____Excellent ____Good ____Fair ____Poor

2. Are you aware of any physical conditions which would affect children in his/her care?
   ____Yes ____No If yes, please explain.

3. Are you aware of any mental health conditions which would affect children in his/her care?
   ____Yes ____No If yes, please explain.

4. Are you aware of any other health issues that we should be aware of?
   ____Yes ____No If yes, please explain.

5. Is this individual in need of psychological or psychiatric evaluations?
   ____Yes ____No If yes, please explain.

I certify that the person named above is free from any communicable or infectious diseases that could be detrimental to a child and that the above information is true and accurate, to the best of my knowledge.

Physician's Signature:_____ **Date:**_____

Physician's Full Name (Print):_____ **License #:**_____

Address:_____ **Phone #:**_____

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