

MEDICAL REPORT ON PROSPECTIVE ADOPTING PARENTS

Name: _____ Date of Exam: _____
Address: _____

Check if applicant has had any of the following, and advise date of illness:

	(Check/Date)		(Check/Date)
Psychological Disorders	_____	Rheumatoid Arthritis	_____
Neurological Disorders	_____	Tuberculosis	_____
Ulcer	_____	Allergies	_____
Diabetes	_____	Substance Abuse	_____
Heart Disease	_____	Cancer	_____
Surgery	_____		

Any other illnesses we should know about: _____

If there is a history of the following in the family, indicate relationship of persons affected.

	(Check/Relationship)		(Check/Relationship)
Deafness	_____	Development Delays	_____
Epilepsy	_____	Psych. Disorders	_____

PHYSICAL EXAMINATION

Skin	_____	Mental Status	_____
Eyes	_____	Emotional Stability	_____
Ears	_____	Height	_____
Lumps	_____	Endocrinopathy	_____
Chest X-Ray (if nec.)	_____	Sight	_____
Heart	_____	Hearing	_____
Blood Pressure	_____	Pulse	_____
Abdomen & G.I. Tract	_____	Reflexes	_____
G.U. Abnormalities	_____	Urine	_____
Nervous System	_____		

Other abnormalities or infirmities:

Prescribed medications being taken:

Reason for infertility:

Are there any medical reason which may affect the applicants ability to be an adoptive parent? Yes / No

If "YES" please explain:

How long have you known the patient? _____

Would you say this patient is in good health? _____ Yes _____ No

Please return to:

CHRISTIAN ADOPTION SERVICES
Suite 201B 9705 Horton Road S.W., Calgary, AB T2V 2X5 _____
Phone: 403-256-3224 Fax: 403-256-8367 Date _____

Signature of Physician _____ Print Name _____

Full Address _____ Phone Number _____