adoption support services of Florida

PHYSICIAN'S REPORT

Applicant' Full Name (Please Print) **Date of Birth**

Applicant's Height:_____ **Applicant's Weight:**_____

The applicant named above is a prospective adoptive parent. Please answer the following questions regarding their current medical condition. If you circle a "YES" response, please attach an explanation of your findings to this form.

	Circle Response	
Does applicant have a personal or family history of any life threatening disease?	NO	YES
Does applicant suffer from any contagious disease?	NO	YES
Has applicant ever been hospitalized?	NO	YES
Has applicant ever had major surgery?	NO	YES
Does applicant currently have a disabling mental disorder?	NO	YES
Does applicant have a chemical dependency?	NO	YES
Has applicant ever undergone infertility tests or treatment?	NO	YES
Is applicant infertile?	NO	YES

_____
Applicant's Printed Full Name is presently in good health, free of communicable disease, and he/she has no physical limitations that would prevent him/her from parenting an adopted child.

_____
Physician's signature **Date Signed**

Physician's Printed Full Name Provider License Number

Address City State Zip Telephone