

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
Medical Evaluation of an Adult in a Foster or Adoptive Home

Form Distribution
- Licensing worker/supervisor
- Kept in a sealed envelop in the
licensing file and marked
"CONFIDENTIAL"

Name of Person Examined: _____ Date: _____
Date of Birth: _____ How long have you been treating this patient? _____

This form will aid the Department in determining the physical wellness and capabilities of adults in foster or adoptive homes who are or may be caring for children. Please complete the following summary of health problems, conditions, and medication use that may affect the adult's ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and for the foreseeable future (five to ten years). If you have any questions or need additional information, please call the Department of Children and Family Services at 312-814-5693.

I am available to discuss further health concerns

Concerns or questions about confidentiality issues may be address to:

Name Phone

I. HISTORY

1. Check any health problems:

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Obesity | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Poor Ambulation | <input type="checkbox"/> Confusion | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weak/Frail | <input type="checkbox"/> Dementia | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Vision | <input type="checkbox"/> Epilepsy/Seizures | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing | <input type="checkbox"/> Strokes/Paralysis | |

Explain *all* medical condition(s) checked and any other chronic conditions:

2. Are there any condition(s) that are progressive in nature? Yes No

If yes, explain: _____

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next ___5 years, ___10 years ___15 years? If yes, explain: _____

4. Medication(s): _____

Are there any physical limitations as a result of medication(s)? Yes No

If yes, explain: _____

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol _____
Tobacco _____

Drugs _____
Other _____

6. Date _____ Result of Tuberculin Test (initial exam only): _____

7. Date _____ Result of Chest X-Ray (if necessary): _____

II. PHYSICAL EXAMINATION

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

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

- 1. Lift a child:
Under 6 months Yes No
6 months to 3 years Yes No
- 2. Walk/maneuver 50-100 feet without major difficulties: Yes No
- 3. Bend/stoop, kneel, reach: Yes No
- 4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes No
If Yes, what type? _____
- 5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:

Lift from a bed to chair, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Frequent Feedings	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Frequent Suctions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Frequent Monitoring	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Frequent Medication	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Frequent Nebulizations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
Frequent Treatments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>

Are any limiting conditions temporary? Yes No

If yes, which condition(s): _____

For each condition, how long will the limitation exist? _____

I certify that this individual is found free from symptoms of communicable disease.

Yes No If No, explain: _____

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.

Yes No If No, explain: _____

Physician's Signature: _____ Date: _____

State License Number: _____

Address: _____

Telephone: _____