Ohio Department of Children and Youth

**MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT**

**AND ALL HOUSEHOLD MEMBERS**

**Section I - For all applicants and household members.**

|  |  |
| --- | --- |
| Name (*LAST, FIRST, MIDDLE*) | Date of Birth |
| Address (*Street, City, State and ZIP*) | |

1. Have you had treatment for a serious or chronic illness? …………………..…….....  Yes  No

Have you been hospitalized in the past five years? …………………………….…  Yes  No

Have you ever received, or been advised to seek, mental health services? …….…….…….  Yes  No

Have you ever received, or been advised to seek, treatment for

alcohol or substance abuse? ……………………………….……………..…………… .  Yes  No

If any are checked, please explain:

2. Have you or your parents, grandparents, or siblings had any of the following? (*Check all that apply and indicate whom*)

|  |  |
| --- | --- |
| Arthritis | Heart Disease |
| Asthma | Hypertension |
| Cancer | Kidney Disease |
| Epilepsy | Tuberculosis |
| Diabetes | Ulcers |

If any are checked, please explain:

3. Is there a history of other hereditary disease? ……………………………………………………..  Yes  No

If yes, please explain:

|  |
| --- |
| **Attach an official copy of the individual’s immunization record as applicable to the requirement of childhood immunizations (children living in the home), pertussis immunizations (everyone in home caring for infants), or annual flu immunization (everyone in home caring for infants and any age child with medical needs).** |
| There are exemptions available to the immunization requirements pursuant to Ohio Administrative Code. Please list all required immunizations which the person listed above has not received and whether it is medically contraindicated, medically inappropriate, or declined by the individual/parent. |
| I have declined immunizations for the person listed at the top of this form for reasons of conscience, including religious reasons. |

|  |  |
| --- | --- |
| I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. | |
| Signature of applicant, household member or parent/legal guardian | Date |

**Section II - For applicants only.**

|  |  |
| --- | --- |
| Date you completed the physical examination of this individual | Date you last treated this individual |
| Do you provide services to this individual?  Regularly  Occasionally  First Time | |

Please respond to each of the following to the best of your knowledge:

1. Does this individual suffer from an illness, including a communicable disease, that would be

detrimental to the care of a foster/adoptive child placed in his/her home? …………………………..……………  Yes  No

2. Are there any chronic or serious disorders for which this individual has received treatment? …….………………  Yes  No

3. Is this individual currently taking medication? …………………………………………….………….……………  Yes  No

4. Is this individual experiencing any physical, behavioral or emotional problems that would be

detrimental to a foster/adoptive child placed in his/her home? …………………………………….…..…………..  Yes  No

5. Have you ever referred this individual to other medical services, mental health services or

treatment for alcohol/substance abuse? …………………………………………………………………………….  Yes  No

If the answer to any of the above questions is YES, please explain:

**(For foster/adoptive applicant only, please complete)**

Please state your professional opinion regarding this individual’s suitability as a foster/adoptive parent from the standpoint of health, considering the individual’s medical history as given on the reverse side of this form and from knowledge you have of the

individual.

|  |  |
| --- | --- |
| AUTHORIZATION FOR RELEASE OF INFORMATION  I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and  correct. I further authorize the physician completing this form to release any information he/she may  have concerning my physical or mental health to:    (*Name of Agency*) | |
| Signature of Applicant | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature | Date | Name *(Print or Type)* | |
| Please check one of the following:  Licensed Physician  Physician Assistant  Clinical Nurse Specialist  Certified Nurse Practitioner  Certified Nurse-Midwife | | Work Address | |
| Work Phone Number | State License Number |

**NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rules.**

Ohio Department of Children and Youth

**INSTRUCTIONS FOR COMPLETING DCY 01653, MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT AND ALL HOUSEHOLD MEMBERS**

**USING THIS FORM**

1. This form is used to determine the suitability of an applicant to be a foster caregiver or adoptive home.

**SECTION I**

1. This section is to be completed for each applicant and each household member. Each individual or parent/legal guardian will complete the information and sign the form. No other signatures are necessary for this section.

**SECTION II**

1. This section is only for applicants and not for household members. A physical exam is required and must be completed by a licensed physician, physician assistant, clinical nurse specialist, certified nurse practitioner, or certified nurse-midwife.