Families through ADOPTION

Child Name: _____

Creating a legacy of thriving families from the adoption plan to child's independence

CHILD MEDICAL

Child's Full Name: _____ Date of Birth: _____

A. **Please check (√) the following items:**

Medical Problem	Now	Past	Never
AIDS or ARC			
Allergies			
Anemia			
Arthritis			
Asthma			
Blackout or Fainting			
Bleeds Easily			
Bowel Problems/Encopresis			
Breathing Problems			
Broken Bones			
Cancer or Tumors			
Chest Pain/Pressure			
Chills			
Choking			
Colds/Sore Throat/Flu			
Cough up/vomiting Blood			
Dental Problems			
Developmental Delays/disability			
Diabetes/Hypoglycemia			
Difficulty swallowing/eating			
Eating Problems			
Eye/Vision Problems			
Headaches/Migraines			
Head Injury			
Hearing Problems/Impaired			
Heart Disease/Attack			
Hepatitis			
Hernia			
High Blood Pressure			
High Fevers/Delirium			
HIV Positive			

Medical Problem	Now	Past	Never
Immunizations completed			
IV Drug use			
Kidney/Bladder Problems			
Lung Disease			
Menstrual problems			
Muscular weakness			
Nausea / vomiting			
Neurological disease			
Night sweats			
Rheumatic Fever			
Seizures			
Severe or chronic pain			
Severe or persistent Vomiting			
Sexual Problems			
Sexually Transmitted Disease			
Shortness of breath			
Sinus infections			
Skin Problems			
Sleep problems			
Speech Impairment			
Stroke			
Surgeries			
Sweating			
Swollen Ankles/feet			
Trembling			
Thyroid Problems			
Tuberculosis			
Unplanned Weight Gain			
Unplanned Weight Loss			
Wetting/Enuresis			
Urinary Tract Infections			
Other:			

Comments: _____

A. Has your child experienced delays in the following? **Check all that apply:**
____Sitting ____Standing ____Walking ____Talking

B. **Prenatal** – Check (√) all that apply to the **mother:** ___ Adopted child: prenatal information unknown
___ Pregnancy complications ___ Delivery complications ___ Use of drugs while pregnant
___ Use of alcohol while pregnant ___ Use of tobacco while pregnant ___ Significant illness during pregnancy

C. **Sleep**
1. On average, how many hours does this child sleep daily? _____ hours.
2. Does this child have trouble with sleep (such as falling asleep, staying asleep, arising in the morning, nightmares, etc.)?
□ No □ Yes If yes, describe: _____

D. **Appetite**
Do you have any concerns with this child's appetite or eating behaviors? □ No □ Yes
If yes, describe: _____

Families through ADOPTION

Child Name: _____

Creating a legacy of thriving families from the adoption plan to child's independence

E. Medications

Is this child currently taking any prescribed medication? □ No □ Yes

If **yes,** please list:

Name of Medication	Dosage	When taken	For What	Prescribed By:	Effective?	
					Yes	No

1. Does this child currently have, or has ever had medication allergies? □ No □ Yes
   If yes, indicate medication: _____

2. Has this child ever had a negative reaction to any medication? □ No □ Yes
   If yes, indicate medication: _____

HEIGHT: _____ WEIGHT: _____

F. PHYSICAL LIMITATIONS OR RESTRICTIONS:

□ None
□ Describe: _____

G. HEALTH CONCERNS, DIAGNOSES, OR FINDINGS:

_____

_____

_____

_____

PHYSICIAN'S FINDINGS:

□ Free of communicable diseases
□ Immunizations current
□ Places no unmanageable health risks to family members
□ May jeopardize the health/well being of siblings by _____

PHYSICIAN'S RECOMMENDATIONS:

□ Capable of handling adoptive sibling relationship(s)
□ Medically and/or physically unsuited to adoptive sibling relationship(s)

PHYSICIANS NAME (PRINT): _____ **LICENSE NUMBER:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

PARENT SIGNATURE: _____ **DATE:** _____