# Clark County Department of Family Services

## Foster Care Physical Examination (Adult Applicant)

Applicant: _____ Date of Birth: _____

I hereby give my permission to the undersigned physician to release complete information regarding my physical and emotional health, including any medications I am using and any medical or psychiatric diagnoses to the Clark County Department of Family Services for the purposes of fostering. *Medical examinations must be current within one year of application.*

_____ _____

Signature Date

**HEALTH HISTORY:** (check all that apply)

- ☐ Hypertension
- ☐ Stomach/bowel disease
- ☐ Emotional/mental illness
- ☐ Heart disease
- ☐ Arthritis
- ☐ Serious Injury
- ☐ Diabetes
- ☐ Neurological disease
- ☐ Surgery
- ☐ Cancer
- ☐ Degenerative condition
- ☐ Asthma/lung disease
- ☐ Hepatitis/TB
- ☐ HIV-AIDS
- ☐ Other:

Please explain (including dates and treatments): _____

_____

_____

Describe any physical limitations: _____

_____

_____

Describe any current illness or medical condition: _____

_____

_____

List current medications and describe their use (prescription and non-prescription): _____

_____

Name of prescribing doctor: _____

**HISTORY OF INFERTILITY:** (check all that apply)

- ☐ Hysterectomy
- ☐ Vasectomy
- ☐ Tubal ligation
- ☐ Miscarriage
- ☐ Endometriosis
- ☐ Male factor
- ☐ Stillbirth
- ☐ Ovulation irregularities
- ☐ Unknown
- ☐ None
- ☐ Other

Describe infertility treatment, dates, and outcome, including surgery: _____

_____

Ability to have a child is: ☐ Average ☐ Unlikely ☐ Very unlikely ☐ Impossible

**PHYSICAL EXAM:**

Height: _____ Weight: _____ Date of exam: _____

General health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Describe any medical concerns: _____
_____
_____

**EVALUATION:**

How long have you known the applicant? _____

What is your evaluation of this person's physical and emotional status at this time? _____
_____
_____
_____

Do you have any follow-up recommendations for this person regarding their health? Yes ❑ No ❑ If yes, please explain. _____
_____
_____
_____

Would you recommend this applicant as a foster parent? Yes ❑ No ❑ _____
_____
_____

_____
Printed name of Examining Physician

_____
Signature of Examining Physician

_____
Date

*Please attach business card here.*

Thank you for your participation. Please contact Clark County Department of Family Services at (702) 455-7200 with any questions or comments.

**Please note**: It is recommended that a copy of this Medical Assessment be stored in the patient's file. Occasionally, agency staff needs to contact the physician's office for clarification.