BRITISH COLUMBIA | Ministry of Children and Family Development

Medical Report On Applicant

The personal information requested on this form is collected under the authority of, and will be used for the purpose of administering the *Adoption Act* and/or the *Child, Family and Community Service Act* (CFCSA). Under certain circumstances, the collected information may be subject to disclosure as per the CFCS Act and/or the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use or disclosure of this information, please call Enquiry BC at 1 800 663-7867 and ask for the listing for the Child Welfare Policy Office or the Provincial Adoption Office of the Ministry of Children and Family Development.

A medical report is required for the assessment process. This form may be completed by one of the following medical practictioners: a Physician, a Naturopathic Physician or a Nurse Practitioner. Please use a pen and print clearly.

To Be Completed By The Applicant

Section 1 Applicant

Applicant's Name (First, Middle and Last)		
Home Address		Phone Number (999) 999-9999
City/Town	Province	Postal Code

Section 2 Applicant's Medical Practitioner

Medical Practitioner's Name		Phone Number (999) 999-9999
Office Address		
City/Town	Province	Postal Code

Section 3 MCFD Office Contact Information*

Name of Worker		Phone Number (999) 999-9999
MCFD Mailing Address		
City/Town	Province	Postal Code

* Contact your Resource/Adoption worker to obtain the mailing address. For assistance in locating a worker in your region, contact Enquiry BC at 1-800-663-7867 for the telephone number of the MCFD office nearest you.

Section 4 Consent

Please provide the Ministry any pertinent medical information, in order to establish my physical and emotional ability to care for children and help the Ministry of Children and Family Development assess my suitability to meet the needs of a child through adoption or fostering.

I consent to the disclosure of the information and permit you to release the information to the Ministry for the period of one year, or until this date (YYYY/MM/DD) _____ , or when this condition/event (please specify) _____ is complete. I am aware that I can revoke my consent at anytime by notifying the MCFD office (identified in Section 3) in writing. I also authorize you to discuss the contents of this report with my worker.

Applicant's Signature	Date (YYYY/MM/DD)

To Be Completed By The Medical Practitioner

Please use a pen and print clearly. If more space is required, please attach separate sheets. For the purpose of this report, examination means any physical examination, laboratory test, or other assessment which in the opinon of the physician is necessary to assess the physical and mental health of the applicant to be a caregiver for children. We appreciate your answers to the following questions.

Please identify your role with the applicant:

☐ Physician ☐ Naturopathic Physician ☐ Nurse Practitioner

1. On what date did you examine the applicant for this report?

_____
Date (YYYY/MM/DD)

2. How long has the applicant been known to you? Since:

_____
Date (YYYY/MM/DD)

3. Please describe any health problems that could affect the applicant's ability to provide for the physical, emotional and personal care of the child(ren) now and in the future.

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4. To your knowledge, has the applicant ever received or required treatment for any emotional problems? ☐ No ☐ Yes
If yes, please specify the nature of the problem and the type and dates of any treatment received.

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5. To your knowledge, has the applicant ever received or required psychiatric treatment? ☐ No ☐ Yes
If yes, please specify the nature of the problem and the type and dates of any treatment received.

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6. To your knowledge, has the applicant ever received or required treatment due to misuse of drugs (prescribed or illicit) and/or alcohol? ☐ No ☐ Yes
If yes, please specify the nature of the problem and the type and dates of any treatment received.

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When completed, please mark as **"PERSONAL AND CONFIDENTIAL"**
and return to the worker at the address as identified in Section 3

7. To your knowledge, has the applicant ever attended your office or the emergency room for treatment of injuries that were the result of domestic violence? ☐ No ☐ Yes

To your knowledge, has the applicant ever received treatment for injuries that left you or another medical practitioner suspicious that domestic violence may be occurring in the home? ☐ No ☐ Yes

If you answered yes to either question, please provide details including the dates.

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8. To your knowledge, does the applicant seek appropriate medical treatment and follow through with treatment when indicated? ☐ No ☐ Yes

If no, please provide an explanation.

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9. To your knowledge, does the applicant take appropriate prevention/early detection steps with regard to his/her health? ☐ No ☐ Yes

If no, please provide an explanation.

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10. Is the applicant currently prescribed any medication? ☐ No ☐ Yes

If yes, please list the medication and related diagnosis.

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11. Please comment on the applicant's general health and give your opinion as to whether the applicant's physical and mental health enables them to undertake and follow through with the responsibilities of an adoptive parent or foster caregiver.

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Medical Practitioner's Signature	Date (YYYY/MM/DD)

When completed, please mark as **"PERSONAL AND CONFIDENTIAL"**
and return to the worker at the address as identified in Section 3