Arkansas Department of Human Services
Division of Children and Family Services
GENERAL MEDICAL REPORT

Mail completed form to:

(Name) _____
(Street Address) _____
(City, State, Zip) _____

To Whom It May Concern: I hereby give my consent for the doctor to release the following medical and other pertinent information regarding me/my child to the Division of Children and Family Services. The findings of this report are to verify freedom from any physical/emotional health condition that would affect the welfare of a foster/adopted child placed in my home.

_____ _____
Date Name of person being examined

_____
Address, City, State, Zip

_____ _____
Name of Parent (if person examined is a minor) Signature of Parent (if person examined is a minor)

PHYSICIAN'S REPORT / MEDICAL HISTORY

Any additional comments should be made on a separate sheet of paper attached to this form.

DOB _____ **Height** _____ **Weight** _____ **Scalp and Skin** _____
Eyes _____ **Ears** _____ **Nose** _____ **Throat** _____
Teeth _____ **Glands** _____ **Chest/Lungs** _____ **Heart** _____
Blood Pressure _____ **Kidneys** _____ **Genitalia** _____ **Extremities** _____
Reflexes _____ **Nervous Disorders** _____
Orthopedic Conditions _____

Please list medications (for both physical and mental health) that may interfere with individual's ability to care for children.
_____

Please indicate any chronic conditions for which individual has received treatment in the last six months. _____
_____

Please list major illnesses and surgeries. Give the date and name of physician for each surgery.
_____
_____

FOR CHILDREN ONLY Are immunizations up to date? YES ☐ NO ☐ If no, identify needed immunizations:
_____

FOR ADULTS ONLY Insofar as you know of this person's physical, mental and emotional health, do you consider him/her a suitable person to have the responsibility for the care of children? YES ☐ NO ☐ If no, please explain.
_____
_____

_____ _____
Name of physician (print or type) Signature of physician Date

Business address _____