**Adoptive Parent Health Report**

**Use of form:** Use of this form is required and meets the requirement of DCF 50.05(6)(h). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each adoptive parent shall present this form to a physician, nurse practitioner, or physician’s assistant to be filled out and signed upon completion of the required health examination. The sections in this document are to be completed by the following individuals:

* Section 1 – Adoptive Parent and Public Adoption Agency Staff
* Section 2 – Public Adoption Agency Staff
* Section 3 – Adoptive Parent and/or Medical Provider
* Section 4 – Medical Provider
* Section 5 – Medical Provider
* Section 6 – Medical Provider

The agency shall file the completed health report in the adoptive family record.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SECTION 1: RELEASE OF INFORMATION**  The following information should be completed by the adoptive parent and/or public adoption agency staff and must be signed by the adoptive parent. Section I may be attached separately when sending this to the medical provider to ensure that the form remains fillable. | | | | | | |
| I hereby authorize the medical provider (physician, nurse practitioner, physician’s assistant) to release medical information as covered in this form to the following individuals who are employees of AGENCY NAME | | | | | | |
|  | | | and |  | | |
| Public Adoption Professional(s) Full Name | | |  | Public Adoption Supervisor Full Name | | |
|  |  |  | | |  |  |
| Adoptive Parent (Patient) Full Name |  | Adoptive Parent Signature | | |  | Date (mm/dd/yyyy) |
|  | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 2: AGENCY CONTACT INFORMATION**  The following information should be completed by the public adoption agency staff. | | | | | | | | |
| If you have any questions, please contact the agency: | | | | | | | | |
| Agency Contact Full Name: | | | | | | | | |
| Agency Contact Email: | | | | | Agency Contact Phone Number: | | | |
| Preferred Method for Returning Form: | | | | | | | | |
| Email | | | |  | | Mail | | |
| Please email the form to the following address: | | | |  | | Please mail the form to the following address: | | |
| Agency Contact Email: | | | |  | | Agency Name: | |  |
|  | | | |  | | Agency Contact Full Name: | | C/O |
|  | | Agency Address: | |  |
| **SECTION 3: MEDICAL PROVIDER CONTACT INFORMATION**  The following information should be completed by the adoptive parent or medical provider. | | | | | | | | |
|  | | | | | | | | |
| Medical Provider Full Name | | | | | | | Clinic Address (Street, City, State, Zip Code) | |
| Clinic Name | | | | | | |
| Clinic Phone Number | | | | | | |
| **SECTION 4: PHYSICAL EXAM INFORMATION**  The following information should be completed by the medical provider. | | | | | | | | |
| The following information is regarding | |  | | | | | | |
|  | | Adoptive Parent (Patient) Full Name | | | | | | |
| who was examined on |  | by |  | | | | | |
|  | Date (mm/dd/yyyy) |  | Medical Provider Full Name | | | | | |

| ADOPTIVE PARENT (PATIENT) FULL NAME: | | | | | | | |  | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 5: PERSONAL MEDICAL HISTORY & EXAMINATION FINDINGS**  The following information should be completed by the medical provider | | | | | | | | | | | | |
|  | How long has the above applicant been your patient? | | | | | |  | | | | | |
|  | Does the patient presently have or have a history of a diagnosis or condition that would impact their ability to care for a child until the age of 18? Include how this impacts daily functioning and prescribed treatments.  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | Does physical examination of the patient reveal any issues or concern not mentioned above that may impact their daily functioning and/or their ability to care for a child until the age of 18?  Please include the affected body part(s)/systems and any identified treatments that were prescribed or recommended.  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | | |
|  |  | | | | | | | | | | | |
|  | | What medications are the patient currently taking and what are they being used to treat?  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | |
|  | |  | | | | | | | | | | |
|  | Does the patient have any personal habits that might affect or impact health conditions?  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | | |
|  | **Yes** | | **No** | **Unknown** | **Type** | | | | | **Explanation and/or Amount** | | |
|  |  | |  |  | Smoking | | | | | If “yes”, please include amount and frequency | | |
|  |  | |  |  | Drinking alcoholic beverages | | | | | If “yes”, please include amount and frequency | | |
|  |  | |  |  | Use of other or illicit drugs | | | | | If “yes”, please include type, amount, and frequency | | |
|  |  | |  |  | Other | | | | |  | | |
|  | | What treatments or changes to habits have you recommended to the patient?  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | |
|  | |  | | | | | | | | | | |
|  | | Please include any other significant medical history information that was not included above and is relevant to the patient’s daily functioning and/or their ability to care for a child until the age of 18:  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | |
|  | |  | | | | | | | | | | |
| **SECTION 6: RECOMMENDATIONS**  The following information should be completed by the medical provider | | | | | | | | | | | | |
|  | | Based on your knowledge of the patient and your findings of the examination, is there anything you think would adversely affect or impact the patient’s ability to provide care to an adopted child?  Please include additional information on an attachment if additional space is needed. | | | | | | | | | | |
|  | | Yes | | | | No | | | | | | |
|  | | If yes, please explain: | | | | | | | | | | |
|  | | | | | | | |  |  | |  |  |
| Provider’s Full Name | | | | | | | |  | Provider’s Signature | |  | Date Signed  (mm/dd/yyyy) |