One Church, One Child of Florida, Inc.

PHYSICIAN'S REPORT ON ADOPTIVE APPLICANT

The individual named below has applied to become an adoptive or foster parent. One of the requirements is that a physician's report be completed. We are asking that you provide this information by completing this form. Please mail the completed form to the address below within 3-5 days. Thank you.

Name____ Date of Examination______________________

How long has patient been under your care? ____

Height________ Weight______ Temperature________________ Blood Pressure_______

Laboratory Serology: Date________________ Negative_____________ Positive_______

Tine Test: Date________________ Negative_____________ Positive_______

Urinalysis (specify diagnosis, if not within normal limits)____

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History of previous illnesses and/or surgery (continue on reverse)_______________________________________

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Physical Findings (check if normal; describe any abnormal findings below)

1. Eyes_____________
2. Ears______________
3. Nose_____________
4. Throat____________
5. Mouth____________
6. Circulatory______________
7. Heart__________________
8. Lungs_________________
9. Abdomen_______________
10. Extremities______________
11. Genito-Urinary__________________
12. Gynecological___________________
13. Neurological____________________
14. Other__________________________

Describe any Abnormalities Noted Above (continue on reverse)____

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Characteristics of Disability, if any (continue on reverse)

Stable_______________ Progressive__________ Improving____________

____
Physician's Signature

Please Mail To:
Vera Jones, MSW
One Church, One Child of Florida, Inc.
Claude Pepper Building, Room 806
111 W. Madison Street
Tallahassee, Florida, 32399