|  |  |
| --- | --- |
|  | **Tennessee Department of Children’s Services**  **Foster Parent/Other Adult Medical Report** |

Foster Parent  Other Household Adult

|  |  |
| --- | --- |
|  |  |
| ***First Name*** | ***Last Name*** |

**To be completed by Foster Parent or Other Household Adult:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SMOKING**  Do you smoke? | Yes  No | | | | | | | Number/packs of cigarettes per day | | | |  |
| Do you drink alcohol? | | | Yes  No | | | | Frequency and amount: | | |  | | |
|  | | |  | | | |  | | |  | | |
| **MEDICAL** | | | | | | | | | | | | |
| Primary Care Provider | | |  | | | | | | Date of last physical | |  | |
| Current Specialists (list types and dates of last visits): | | | | | |  | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Special needs or disabilities** | | | | |  | | | | | | | |
|  | | | | | | | | | | | | |
| **Current Medical Problem** | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| **Current Medications** | |  | | | | | | | | | | |

|  |  |
| --- | --- |
| **Date of Last Influenza Immunization** |  |

|  |  |
| --- | --- |
| **Pertussis Vaccine Date (Adult Inoculation)** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **MENTAL HEALTH**  Have you ever been treated or hospitalized for a mental illness or suicide thoughts/attempts? | | Yes  No | |
| If yes, list physician, dates and treatment: |  | |
|  | | | |
|  | | | |

**To be completed by medical professional:**

|  |  |
| --- | --- |
| **TB Risk Assessment** **Date/Results:** |  |
| **and/or**  **TB (PPD) Date/Results:** |  |
| **or**  **Not at Risk**  **Low Risk** | |

Specify any physical, mental, or emotional problems which would affect this person’s ability to care for a child. If the person is identified as other adult living in the home, indicate conditions detrimental to a child’s placement in the home.

|  |
| --- |
|  |
|  |
|  |

I recommend  do not recommend this person as a foster or adoptive parent for children.

|  |  |  |
| --- | --- | --- |
| **Physician/NP/PA Print Name** |  |  |

*I am not the primary care provider for this individual and am completing this form based on a single exam in combination with the information provided by the individual the day of the exam.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Physician/NP/PA Signature** |  | **Date** |  |