|  |  |
| --- | --- |
|  | **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** |  |