|  |  |
| --- | --- |
|  | **Tennessee Department of Children’s Services****Medical Self-Report**  |

|  |  |
| --- | --- |
| **FOR:** | **[ ]  Foster Parent** **[ ]  Other Adult** **[ ]  Child** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last Name:** |       | **First Name:** |       | Foster Home ID: |       |

**MEDICAL**

**CURRENT MEDICATIONS & DOSAGE** (List all prescription and over the counter medications you are

|  |  |
| --- | --- |
| currently taking) |       |
|       |

**ALCOHOL and TOBACCO HISTORY AND FREQUENCY**

Any past or current tobacco or alcohol usage? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| If yes, please explain: |       |
|       |

**ILLEGAL DRUGS HISTORY AND FREQUENCY**

Any past or current illegal drug usage? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| If yes, please explain: |       |
|       |

**ALLERGIES** (medication, food, insect stings, etc) [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| Specify: |       |

|  |  |
| --- | --- |
| **SPECIAL DIET:** |       |

Have there been any medical updates since the last assessment: [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| If yes, please describe: |       |
|       |

|  |  |  |
| --- | --- | --- |
| Date of last physical: |       |  |

**MENTAL HEALTH**

Have you been treated or hospitalized for a mental illness or suicide thoughts/attempt within the last twelve months? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| If yes, list dates and hospital: |       |

Have you had a psychological evaluation within the last twelve months? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| If yes, list date and provider: |       |

***For Children Only:***

**IMMUNIZATIONS**

Are immunizations up to date? [ ]  Yes [ ]  No [ ]  N/A

**Other Comments:**

|  |
| --- |
|       |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |