

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency  
Family Licensing Division



**Medical Report for Applicant and All Members 18 Years of Age or Older Residing In Prospective Foster / Adoptive / Kinship Home**

Name: \_\_\_\_\_ Sex: Male  Female

Date of Birth: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Number Street Apt# (if applicable) City State Zip code

I have examined the above-named person and certify that he/she is:

1.  Free from disease in communicable form.
2.  In satisfactory physical condition, which will permit close association with children, without danger to them.

In addition to the above questions the following tests need to be completed:

Tuberculin test (by the Mantoux method) Date: \_\_\_\_\_ Result: \_\_\_\_\_

Chest X-Ray (in a positive reactor) Date: \_\_\_\_\_ Result: \_\_\_\_\_

Comments: \_\_\_\_\_

**Findings:**

Please provide a summary of medical, emotional or substance abuse problems or condition, if any, which may affect the individual's ability to work with or provide care for children.

\_\_\_\_\_  
\_\_\_\_\_

**Recommendations:**

Based on this examination, it is my professional opinion that the above individual is medically and emotionally fit to work with or provide care for children.

Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician or Nurse Practitioner: \_\_\_\_\_

Address of Physician or Nurse Practitioner: \_\_\_\_\_

Telephone number: (\_\_\_\_) \_\_\_\_\_

Date of Examination: \_\_\_\_\_