A SECOND CHANCE, INC. / POINT OF CONTACT
MEDICAL EXAMINATION FORM

TO: Examining Physician:
FROM A Second Chance, Inc. Kinship Foster Care Agency
RE: Mr. and Mrs. / Ms. _____ foster / adoptive parent(s) applicant(s)
This examination is required to determine whether the health of the parent(s) permit them to care for a child. Current health as well as prognosis for the future should be considered**. This medical information is for the use of this agency only.** Please return the completed form to the address listed below:

Attention: _____

A Second Chance, Inc.
100 N. 17th St. 7th Floor
Philadelphia, PA 19103

Patient's Name: _____ Date of Birth _____

Weight _____ Height _____ Pulse _____ Blood Pressure _____ Lungs _____

The following test must be completed:

	TUBERCULOSIS
DATE OF TEST	
RESULTS	☐ Negative ☐ Positive
COMMENTS	

Do you recommend any laboratory tests and / or X-rays, including serology? ☐ Yes ☐ No

If yes, please indicate reason: _____

_____

Does the patient have a nervous condition _____

Please comment on the patient's general appearance: _____

_____

Is the patient able to handle the increased stress of parenting an additional child? _____

_____

_____

Is this patient free from communicable diseases? ☐ Yes ☐ No If no, please explain: _____

_____

DATE OF EXAMINATION: _____ HOW LONG HAVE YOU KNOWN THIS PATIENT? _____

PHYSICIAN'S NAME (please print) _____

PHYSICIAN'S SIGNATURE: _____ PHYSICIAN'S ID NUMBER: _____

PHYSICIAN'S ADDRESS & TELEPHONE NUMBER _____

(Note: The TB Test must have been done within the last three months. The Department of Public Health will offer free service.)

PERSONAL HEALTH HISTORY

NAME: _____

Did you ever have any of the following? Give approximate dates.

	YES	NO	DATE		YES	NO	DATE
FAINTING SPELLS	☐	☐		HEARING LIMITATIONS	☐	☐	
MAJOR ACCIDENTS	☐	☐		EPILEPSY	☐	☐	
ANEMIA	☐	☐		SEVERE HEADACHES	☐	☐	
HIGH BLOOD PRESSURE	☐	☐		ORTHOPEDIC PROBLEMS	☐	☐	
HEART TROUBLE	☐	☐		JAUNDICE	☐	☐	
RHEUMATIC FEVER	☐	☐		CHRONIC FATIGUE	☐	☐	
DIABETES	☐	☐		EMPHYSEMA	☐	☐	
TUBERCULOSIS	☐	☐		EMOTIONAL PROBLEMS	☐	☐	
CANCER	☐	☐		PNEUMONIA	☐	☐	
ULCER	☐	☐		CIRRHOSIS	☐	☐	
MENTAL/NERVOUS DISORDER	☐	☐		ARTHRITIS	☐	☐	
ALCOHOLISM	☐	☐		DEPRESSION	☐	☐	
VENEREAL DISEASE	☐	☐		CIRCULATORY DISORDER	☐	☐	
KIDNEY DISORDER	☐	☐		DRUG OR ALCOHOL ABUSE	☐	☐	
HEPATITIS	☐	☐		TUMOR	☐	☐	
POLIO	☐	☐		PARALYSIS	☐	☐	
ALLERGIES	☐	☐		CONVULSIONS	☐	☐	
ECZEMA	☐	☐		MUSCLE DISORDER	☐	☐	
VISION LIMITATIONS	☐	☐		OTHER ILLNESS (SPECIFY)			

LIST ANY HOSPITALIZATION(S), GIVE REASON(S) AND DATE(S):

_____

_____

ARE YOU TAKING ANY MEDICATION(S)? ☐ YES ☐ NO IF YES, LIST TYPE(S) AND REASON(S) FOR TAKING THEM:

_____

_____

DO YOU HAVE OR HAVE YOU HAD ANY MEDICAL PROBLEMS WHICH WOULD LIMIT THE NUMBER AND KIND OF CHILDREN FOR WHOM YOU COULD CARE? ☐ YES ☐ NO IF YES, PLEASE PROVIDE EXPLANATION BELOW:

_____

_____

_____ _____

SIGNATURE DATE