



A Center for Adoption Services

602 Alder Ave NE
Bainbridge Island, WA 98110
206.954.5253
Dru@DruGroves.org
www.DruGroves.org

Adoptive Applicant Medical Report

Name of Physician: _____ Date: _____

Address of Physician: _____

Please return to: **A Center for Adoption Services, 602 Alder Ave NE, Bainbridge Island, WA 98110 – 206.954-5253**

A Center for Adoption Services requests a medical report on _____
We need to know if this person has any chronic, contagious or disabling illness that would interfere with the proper care of a child or children.

Is the patient taking any medication? For what purpose?

Significant Past Medical History:

Current Medical Diagnosis:

Prognosis:

Comments or Impressions:

Does the adoptive applicant have any physical, mental or psychological conditions that would affect the upbringing of a child?

Is the adoption applicant's state of health suitable for raising a child?

Physician's Signature: _____ Date: _____

Print Name of Physician: _____

I authorize my physician to release information to A Center for Adoption Services.

Adoptive Applicant's Signature Date