A Center for
Adoption Services

602 Alder Ave NE
Bainbridge Island, WA 98110
206.780.1972 fax 206.780.1817
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 — 206.780.1972 — Fax 206.780.1817**

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.

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____

VISION: Left _____ Right: _____ HEARING: Left _____ Right: _____

Routine Blood Test: Normal / Abnormal Routine Urine Test: Normal / Abnormal

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